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ADVENTURES IN SALVAGE

BY BERTRICE FARRALL CLARK

Salvage is an old word of Latin origin—"saving from the perils of the sea." During the Second World War, in 1942, it meant—"GET IN THE SCRAP"—potential guns and cartridges! Today has added humane and spiritual values to the salvage process.

Just as farming is not all planting, cultivating and harvesting, but is the sharing in, and the contented feeling of, a job well done; so can pottery, stitchery, weaving, wood and metal work and the unlimited list of crafts contribute to the doer a mental stimulus of pride in usefulness and of social wellbeing. Work with these is occupational therapy—O. T. for short. This is the first basic step, slowly leading the mental patient back to the reality from which flight began. During the summer of 1950 the writer was an occupational instructor in charge of an O. T. group of 30 elderly women, on a state hospital ward of 70 patients. The class was a routine one. Then something happened! All but eight of this group were transferred. The eight left were stolid dullards. The places of those transferred were filled by others considered equally unfit for O. T. Class was discontinued.

The teacher spent a few days cleaning out the ward O. T. cupboard. She soon found that the class, officially ended, was surprisingly alive in the minds of the eight left-overs.

Those eight! They waited for teacher—singly and collectively. There were tears in their eyes, and a few were belligerent. "Why did you leave us? We belong to O. T." Teacher stood it for a while—then asked the senior occupational therapist if the class could be reopened.

The verdict was that the personnel shortage would not permit the assignment of an occupational instructor for the eight "left-overs" when the rest of the aged women on the ward, 62 of them, were considered both mentally and physically disqualified. Teacher agreed, and compromised by giving the "strikers" a little time during the noon hour. After reconsideration, however, the unexpected happened: Class was officially reopened. There were 70 senile patients. It was a challenge. Only eight had been exposed to O. T. However, the fact that the eight had been "deserted" created out of them a conscious demanding nucleus around which grew the later active group of 30.

Class was held for two hours, five days a week. Individual projects were in the majority, such as aprons, crib blankets, cushions, bags, holders, children's scrap books, hoop-woven mats and rag dolls. The perennial fringe of "wall-sitters" was made up of potential members of the class. Group projects however opened up a new approach.

The first day of class brought the eight around the table, but there was no indication that any other ward member was interested. This little group of eight included the maimed, the halt and the blind; but what was lacking physically was made up in enthusiasm. Having started each on a project, the teacher circled the ward to make contacts with other possible class members. This is where "Grandma" entered the picture.

"Grandma" sat watching, her hands gripping a sturdy crooked cane, held upright against her knees, her chubby face shining with interest. Anybody with a "shine" like that couldn't be a poor bet, so the instructor invited her to join the class. The answer was quick in coming.

"I can't see good enough to sew. My mother was blind as a bat and that's what I'll be pretty quick," she said with a broad smile, twinkling eyes, and all in one breath. She wore glasses—with lenses that seemed an inch thick.

She was carrying a good-sized Bible worn with use. It served the double purpose of giving religious inspiration and holding precious letters, cards and clippings, all her worldly goods. Though held tightly under her arm, its leaves stretched out in a wide-open fan. The teacher thought a moment; then, "Let's make a bag to hold your Bible—it won't last long under your arm."

She came right over. Being "Grandma," she was followed by a procession of class prospects. From then on there was no lack of active members—up to 30 of them—about half the ward. The rest can be pictured, lined up against the wall. No interests, no desires, just "wall-sitters"!

Grandma finished her bag; and where she goes, it now goes. She still comes to class, strings marionette yo-yo dolls,* winds balls, weaves rug cord on a rat-tail lap-loom and makes class interesting. If questioned about her eyes, she chuckles and repeats her remark

*See Figure 2.

about her mother, "blind as a bat." She is no longer able to read her Bible. However, she "knows every word of it." Grandma has not changed. She just IS!

* * *

An amazing fact about this ward O. T. group of "doers" is the rich variety of its personalities. Let's look at a few.

There is Esther, who is blind. She sews rags. She had always sewed rags. Finally: "I'm sick of it," said she. "All my life I've done nothing but sew rags!"

At the moment there was no substitute for rag sewing, so the problem boiled down to improving the technique.

" 'Tisn't the work" she said. "I can't see what I'm doing—if the colors look pretty, and if they're right side up."

This is what evolved: a round tin box one foot in diameter by three inches in height; six cardboard partitions radiating from the center, with a notch in the top of one to indicate the compartment holding the red rags. The other five sections continue the rag spectrum in clockwise order. Esther has not always been blind, and to work with known colors seemed magic to her.

It was hard for Esther to wait even for a day before trying it out. A year later she was still thrilled and satisfied. Her sewing technique had improved: she had developed into a proud, socialized member of the group.

* * *

Old Faithful (alias Mattie) was mute when teacher "dragged" her into the group. She became the one who was always first on the job and "rarin'-to-go." As the official ragcutter she felt honored with a special apron of gay colors and ruffles—made for her use in class and kept in the ward O. T. cupboard. This apron gave Mattie a new sense of values worth struggling for. A chance visitor commented on it, and was rewarded with a torrent of words tumbling over each other and explaining the need of an apron, "if you're cutting rags." Teacher, on the other side of the table, looked on in awe; this was Mattie's "maiden speech."

How she can cut rags is a mystery; she is almost blind—with cataracts on both eyes; her sense of touch must be delicate. Of course the rags she cuts are far from straight, and many have little tags along their sides—but who cares? The rag-sewer sews them tightly. The rug weaver weaves them tightly. The final result is colorful, interesting and useful.

The final result for Mattie is awe-inspiring. Today she is at the top of the group in social adjustment; sensitive and jovial in spots, with a delightful sense of humor and an enviable chuckle.

• • •

There are two rug makers: Gladys, who weaves them, and Lena, who crochets them. Both are in the 200-pound class, and both are helpful with ward duties. Gladys has never grown up. Lena is smart.

Lena is a happy worker, and during a year of membership in the O. T. group never reverted to a previous record of violence. She ironed ward clothes in the morning and came to O. T. in the afternoon, all hot and sweaty, but with a beaming smile on her broad face. Come Sunday, however, and work stops for Lena. It is her "day-of-rest" and going-to-church. She rarely misses Sunday mass, and during the week worries about the weather for her next Sunday-church-trip.

• • •

Sometimes the unexpected opportunity for salvage comes on the heels of seeming defeat.

Clara, a typical "Miss Prim," was the first of the "wall-sitters" to desert her "perch." She came over to the group gathered around the table and said with confidence—

"I can make anything. Will you give me something to sew?"

The teacher handed her a pot-holder. The job was to bind its edge with tape. Five, then 10, minutes went by. Silently she gave it back with nothing done. Her hands were too crippled with arthritis to hold a needle. Completely deflated, she turned to leave. Suddenly she caught sight of Mattie's pile of rags, freshly cut, spread out on the table.

"Well," she said in a firm voice—"just look at that! Why can't I fix that mess? It's awful!"

Teacher said "Go right ahead," a direction which was acted upon promptly.

At intervals Clara vociferously objected to Mattie's technique, and finally grabbed a fistful of cut rags to show to teacher. Mattie "told her off," and the fight was on. When she was informed, "Unless you quit fighting you can go back to wall-sitting," Clara shut up.

At the end of class, in front of Clara was her finished project for the day—12 one-inch-square balls of unsewed rags, each made up

of one color, and with the end of the last rag neatly pinned down. She counted them carefully, out loud, then reluctantly handed them over.

What could one do with Clara's little unsewed balls of carpet rags? Unwind them? No! It was her idea and therefore precious.

The next afternoon brought the answer. Nearby was blind Esther with her rainbow-sectioned box of rags, full to overflowing, Neat little compact balls of unsewed rags to take the place of bunched-up tangled ones was a real invention. Thus was born the class' first assembly line, which later proved to be the start of

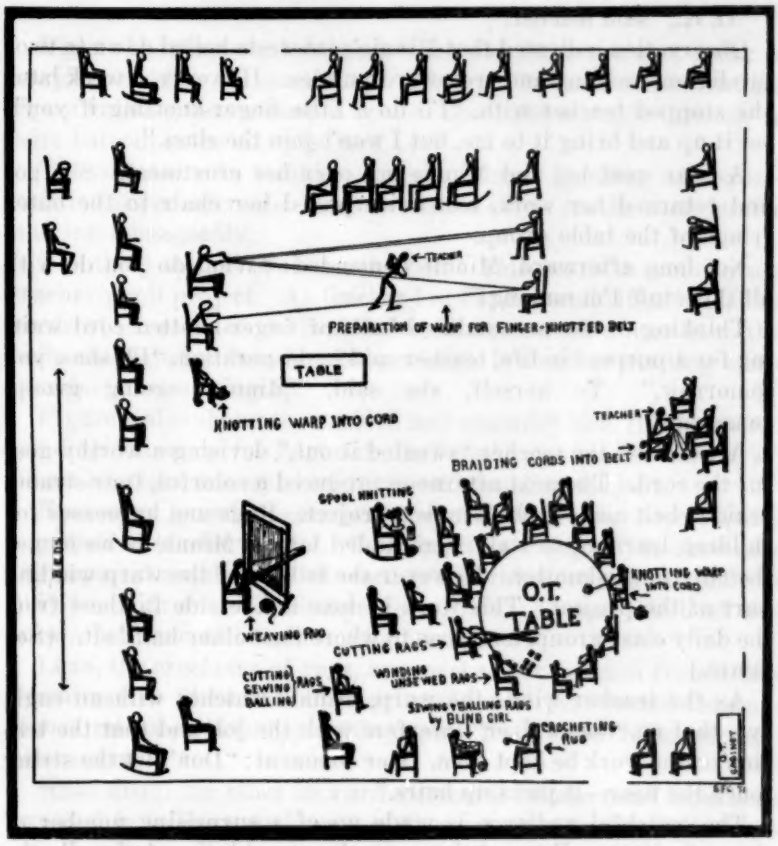

Figure 1. Arrangement of Ward Occupational Therapy Class (Assembly Line Technique)

Note: Black faces represent active class members. White faces are potential class members.

group therapy. Social co-ordination, the goal of all human salvage, could not be far away. Figure 1 shows the rag-rug assembly line. There are: two workers cutting rags; one worker winding cut rags (unsewed) in single-color balls; two workers sewing and balling mixed-color rags; and two workers making rag rugs (1) woven rugs and (2) crocheted rugs.

* * *

Minnie is the aristocrat of the ward, and the originator of the class' second assembly line. When approached to join the class, she "looked down her nose," and said she had plenty of interests without sewing.

"O. K.," said teacher.

Observation indicated that Minnie's interests boiled down to two: prodigious reading and crossword puzzles. However, a week later she stopped teacher with, "I'll do a little finger-knotting if you'll set it up and bring it to me, but I won't join the class."

A year went by, and Minnie got over her crustiness. She got and returned her work, and twice pulled her chair to the outer fringe of the table group.

Not long afterward, Minnie demanded: "What do you do with all this stuff I'm making?"

Thinking of the accumulated balls of finger-knotted cord waiting for a purpose in life, teacher said in desperation, "I'll show you tomorrow." To herself, she said, "Minnie's going group-conscious."

After class, the teacher "sweated it out," devising a worthy goal for the cord. The next afternoon produced a colorful, four-strand, braided belt made from Minnie's project. Rugs and harnesses for children learning to walk were added later. Minnie is no longer the only finger-knotter. However she is boss of the warp-winding part of the project. This work is done at the side farthest from the daily class group, and close to where the "other half" sit. (See figure.)

As the teacher winds the warp, Minnie watches with an eagle eye, that no "floorwalker" interfere with the job and that the tension on the work be kept even. Her comment: "Don't let the string touch the floor—it picks up hairs."

The watchful audience is made up of a surprising number of the wall-sitters. Four of these are chosen each time to handle the warp as teacher winds it. They sit up very straight, or slightly

bent forward, holding the strings as if life depends on what they are doing.

And so the "wall-sitters" watch, the chosen four are proud, and Minnie's ego swells.

* * *

Corabell, the silent one, became the class' only spool knitter. She makes cord similar to that made by finger-knotting, and is one of the charter members of the class. So far she has never been heard to speak a loud word. However, she has improved in looks and tidiness, and has voluntarily joined the group around the table instead of sitting in a far-away corner of the ward.

* * *

Finger-knotting cord is made with the fingers alone, using a varying number of threads. It takes agility and concentration. Spool knitting uses a simple wooden spool and a single thread. A wire hairpin is the accepted tool.

The difference in technique between finger-knotting and spool-knitting is considerable, but the finished cords can be used jointly and interchangeably.

The third step is braiding the belt. This too is a combination teacher-pupil project. As teacher braids, one wall-sitter holds the cords at the start of the braid while three or four others keep the balls untangled as braiding progresses. It's rather exciting when somebody loses her grip.

Figure 1 also shows the braided belt assembly line. It illustrates: winding the warp for finger-knotted cord; making the cord (two finger-knotters, one spool-knitter); and braiding the belt.

Ever since grandma entered class, one picture has been repeating itself in teacher's mind. Grandma (see Figure 2) is obviously the happiest member of this ward group, the most beloved, and the only one with a real devotion to her Bible. Around this book has grown her deep and sincere religious life.

Lena, the crocheter of rugs, approaches her religion from a different angle. She covets the dignity of church service and the emotional release which her faith gives. Both have religious consciousness.

What about the other 68 ward members? Some must have been exposed to religion, and some of these must have retained a conscious religious background. The teacher thought the question worth probing.

Figure 2. "Grandma." This sketch of Grandma was made by the supervising nurse of the ward.

The next day the few members of the ward group able to walk were taken downstairs and out on the lawn to sit—their first experience of its kind for at least a year. The teacher gave a victrola concert for those left behind.

The sewing group was started on its projects, the victrola was opened, and the music began.

First came old melodies, then hymns, and a modern animal record, which brought wholesome laughs from many of the wall-sitters. One old lady actually got up and danced a jig, and she wasn't a member of the sewing class.

The record they asked to hear over again was "The Lord's Prayer," with Nelson Eddy as soloist, a chorus, organ and orchestra. This was played three times by request, and each playing brought a hush over the group. Several offered appreciative comments and "thank you's."

When the outdoor ones returned, one stay-behind member asked to have "The Lord's Prayer" repeated for them. Yes, it was grandma's request.

The next day class met as usual, but with an unexpected bustle of interest. The teacher sensed that those on the fringes of the class appeared to sit straighter. A few wandered over from the wall to the class group, seeming to feel themselves a part of it.

Shortly after class got started, Clara, the rag winder, hesitatingly brought over a handful of her flat little rainbow balls of unsewed rags. She fussed with them, then suddenly exploded into words: "I want to know what you do with them!" The teacher had never told Clara where her rainbow rag-balls went!

Esther, the little blind rag-sewer, sat right behind Clara's chair. Gladys and Lena, the makers of rugs, were not far away. Arm in arm, Clara and the teacher toured the rug-assembly-line. Woven rugs! Crocheted rugs! Clara was speechless with pride and emotion. They were made with *her* rags!

Minnie, the boss-finger-knotter, had asked a similar question not long before. One basic human urge is to belong and have value to somebody or something. The emotional stimulation of music and words seemed quite obviously carried over to the next day. Social co-ordination showed itself in two explicit ways. However, real values are not transient ones, but develop with growth.

The writer feels that, during the year reported, this group of women has grown and has developed a spark of group consciousness and social co-ordination. Many of these "oldsters" are beginning to feel that they, too, "belong."

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FERENCZI

BY MRS. F. H.

Foreword

In presenting this paper about Sándor Ferenczi, I wish to emphasize what is, I think implicit, that it is offered, purely, from the viewpoint of a patient. Although I had been the subject of analysis before, yet the difference between Dr. Ferenczi's approach and the approach of the other analysts I had known was immense. From the first, I was no longer confronted by an "angry Father" or a superdetective, but by a kind latitudinarian whose guiding line was that we are all subject to the same tendencies, the same thoughts and feelings, and that even the most vagrant of them is important.

As to Ferenczi's "active technique," it was the logical working out of his belief that restrictions (of any kind) were not always necessary. He felt that action often released buried material better than passivity, but there were times when a more passive attitude worked well. In this respect, I think of Ferenczi as an artist rather than as an instructor. His instructions were elucidations when the going ceased to be easy. One was helped over the steep places. The outstanding characteristic of Dr. Ferenczi was, without doubt, his humanitarianism. . . . But often his Puckish humor had its way in flashes shining through the more sober stuff. If he was a great humanitarian, he was also, very human.

As a postscript, I feel that if it had not been for his sensitiveness, which was of a very rare sort, it is just possible I should not have had the benefit of his active technique (as I think he always employed what was best for each patient), and I might still be languishing on some couch, even at this late date, trying frantically to unearth what never once raised its head as long as I remained supine!

* * *

When Sándor Ferenczi came for an eight months' visit to this country in the 1920's, I had the great privilege of being one of his patients. I had previously had psychoanalytic treatment; or what had masqueraded in its name. In fact, I had had a whole galaxy of analysts with whom I had earnestly worked, and, be it said in plain justice, who had worked energetically in my behalf. The sum total

of these experiments, however, had been practically nil, except that what I had undergone had made me inclined to despair rather than to hope. As a waggish friend once said: "You are a horrible example of what the most expensive psychoanalysts can do!"

In those "high and far-off" days when analysis was first being purveyed to the American public, the analysts with whom I came in contact could be divided into two groups, the glaring Big Bow-Wow type who brooked no word of criticism, and the mild, ineffectual ones. When I look back upon the trials and errors which were the consequences of their efforts and mine, I believe that while many of these gentlemen did their honest best, yet in spite of the many weary months spent in their consulting-rooms, I could see no end to the matter. It was not until I began analysis with Dr. Ferenczi that I realized why no progress had been made in my case.

From the very first interview with Ferenczi, it became increasingly plain to me why nothing in the slightest degree catalytic had before occurred. Dr. Ferenczi's approach was entirely different from any I had hitherto known. He instructed me not only to say all that I ardently wished to say about the things so sorely vexing me, but invited me from the outset, to speak out anything about himself, even when my thoughts might not be flattering or might be, even, downright rude. This I was instructed to do, as I felt at the beginning, almost too insistently. But I soon began to perceive that this part of the analysis was vastly important; for after the first hurdles in speaking my thoughts about Ferenczi without restraint, the hidden material became unblocked in an amazing manner. Once, in the beginning, when I had been prodded into saying outright what was on the threshold of my mind and had found myself saying what I thought was an unwarrantably unkind thing to this man who so obviously wished to help me, I burst into a torrent of tears. That episode done with, and his complete acceptance of me in all my raw unfriendliness, conveyed to me, the analysis proceeded in excellent order. The effect upon me, a burdened and distraught person, of this wonderful kindness, was immense! For here was a man, whose reputation was of the highest, and who yet thought of himself not as a heaven-sent genius but as a simple sincere person, devoted solely to the task of relieving others, who, unhappily, had fallen by the wayside.

One of the things that impressed me from the first meeting with Ferenczi was that there was practically no misunderstanding of anything I might say. There were no nets spread for my confusion. I had sometimes thought, during my previous experiences with analysts, that one or another of them was trying to confound me, to catch me up. This was due, to a great extent, to my heightened tension, and I afterward realized that I had had a somewhat jaundiced view. But since anyone undergoing a neurosis is like one suffering from a fever of sorts, I cannot, even at this late date, understand the use of pummelling a patient, or dealing in any other way than leniently with one so harassed and at sea. If I seem to dwell on this aspect of my treatment it is to explain the manner in which Ferenczi made possible the rapport necessary for a fortunate resolving of conflicts. (I realize that latterly most analysts, worthy of the trust placed in them, have abandoned the thundering as from Mt. Sinai method!)

So my analysis proceeded well until it struck a snag. The reason for this impasse was that what I had been revealing was more or less on the upper levels; but when the digging became deeper, it stopped there for a while. In endeavoring to discover the reason for this, Ferenczi became aware that many of my worst fears seemed to be concerned with the two ideas of light and of going abroad on the street. In the safety of the room, lying on the couch, they refused to come into consciousness. Furthermore, I had already used the device of remaining supine on my own couch and becoming perfectly still, much as an animal sensing danger will automatically become rigid, in a word I "played dead" to my worst fears.

When this was plain to Ferenczi, he suggested that we venture forth into the street in broad daylight. So began the peripatetic way of carrying on the analysis. For many days, the grisly things trooped out as we walked, threading ourselves through the throngs of people on Broadway. Meanwhile, I talked incessantly. In looking back, I realize that it was a part of the quality of Dr. Ferenczi that in taking a volubly talking woman through the New York City streets, he was as thoroughly at home as in his own room. His purpose was to cure me, so it mattered not one whit to him if we attracted attention or not. When we got back to the hotel the material, tapped, continued to gush out until the end of the hour.

As I have been narrowly quizzed by some of our more orthodox analysts about this method, and about the whole-hearted acquiescence of its use by the man whom, by this time, I always thought of as "the Master," I wish to say unequivocally, that he was at all times ready to utilize any means possible that would bring the desired results; and that, moreover, he never once stood on ceremony when the welfare of a patient was at stake. In this he was, first and last, the good physician.

Although my analysis was not completed during the time which Dr. Ferenczi had allotted to his American visit, and although it was not possible for me to continue it in Budapest, what he taught me was never lost, even if for a while I floundered rather badly. My eventual recovery was, however, due to the months I spent under his tutelage. (As that has been written of elsewhere,* this is not the place for the why's and wherefore's.) Germane to this, I must tell how he often used to say: "You must swallow Ferenczi! You must *swallow* Ferenczi!" This humorous phrase expressed in other words: "I hope that you will accept me, receive me, and take what I have to offer of knowledge and experience; that you will be receptive to it, assimilate it and make it *your own. Then* you will no longer need Ferenczi!" I did do just that, to my great good fortune!

Two attributes of Ferenczi are most notable. I have mentioned his kindness, but I wish to emphasize how unusual, how far beyond anything I have ever experienced, that was. He was gentleness personified. Never was he, even momentarily, impatient. Always was he a refuge from terror, and from the sickening feeling of my unworthiness. Nothing was too trivial for his consideration. Anything a patient was facing was of importance to him. One felt safe, safer with him than with any other man or woman.

He also had his very human side; his humor was delightful. Once when I had given myself over to a session in which a spate of rather funny incidents had come up, he stood chuckling beside me, upon my taking leave, and remarked: "Now, by rights I shouldn't expect payment for this hour, as I have had very good entertainment. I should pay you for it!"

To sum up: Any remembrance of Ferenczi should include his dedication to his patients, his unusual human qualities, his sin-

*Mrs. F. H.: Recovery from a long neurosis. Psychiatry, 15:2, May 1952.

cerity, his sense of values (of which his sense of humor was a part), and his thorough-going humaneness. It was a rare privilege to have known him, for he embodied what we think of when we think of "greatness."

c/o Izette de Forest
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THE VERBAL SELF-PORTRAIT TEST. PART I*

BY WALTER S. BOERNSTEIN, M. D.

In March 1950, the writer had occasion to treat a 25-year-old woman who complained of having been "moderately unhappy" during the previous six months. Rigid, withdrawn, and singularly lacking in insight, she struggled in vain to convey her inarticulate feelings. She offered almost no material. It was necessary to work with the few dreams and incidents she brought to the sessions, and very little progress was made.

To elicit some effective material, I handed her pencil and paper and asked, "Would you please draw yourself?"

She stared at the paper and ignored my question. "Why don't you go ahead," I persisted. "Are you afraid you might give yourself away?"

"Yes," she replied.

I tried another approach. "Would you describe yourself in words?"

Her voice betrayed uneasiness. "Please," she said, "can't we pass that up?"

Then I took a different tack. I asked her this question: *"If you were an ancomplished artist, how would you paint yourself?"*

Her response was immediate. "Motionless," she said. "Nailed to the floor. The nails are driven through my shoes."

"What about your arms?" I asked.

"Hanging loosely."

"Eyes?"

"Well . . . open, I suppose. Looking out at something."

"At what?"

"I suppose at the other people."

"Do the other people look at you?"

"No . . . I'm not aware of it."

"Who are they?"

"I don't know."

"What colors are in the picture?"

"I am wearing my navy-blue dress, and I think also I have the feeling you sometimes get when you see someone standing by a

*This is the first of a series of papers exploring the value and use of the Verbal Self-Portrait Test. The observations and evaluations are the result of the writer's experience with a total of 45 clinical and 10 non-clinical cases.

window, the sunshine coming from behind him. You can't see the face. It is dark. I think I see myself that way—mostly as a dark outline."

"Is there any light in the picture?" I asked.

"It is very dim," she replied.

No further questions were necessary. Without realizing it, the patient had by her answers revealed her basic conflicts. First of all, she stands "motionless." Indeed, she is "nailed to the floor." Such an enforced immobility indicates a severe conflict. Either she is in terror of flying off into a fantasy world, or she is in mortal dread of unleashing destructive impulses beyond her control.

Her loosely hanging arms suggest that she makes no effort to deal with the world. She divorces herself from reality. Though her eyes are fixed on other people, she is not relating to them. She does not even know who they are. She is out of contact with the world.

Along with her isolation comes another clue. The blueness of her dress points up her depression. Her twilight world is a prison of blues and grays. Rich and varied colors are banished. Only "dim light" and "dark outlines" remain. She herself is no more than a silhouette.

In responding to my leading question, an image of her physical self and its surroundings had been *created by the emotional* forces which also had built her neurotic structure. This image stood as a "symbol" of her mental state, picturing her inner turmoil in concrete terms. Though unable to comprehend her own neurotic structure, she was capable of representing it. This she could do by reverting to a primitive level of psychic life—the "pre-logical" or, to use Werner's term, "syncretic" phase (Werner,[1] pp. 53 ff.).

Perceiving, feeling, and thinking are all one at this level. Only the concrete can be comprehended. Rational control is either too weak, or does not yet operate at all. The motor-emotional factors prevail and provoke concrete images (Boernstein[2, 3*]).

All psychic life in early childhood is of this nature. In adults, it continues to function in dreams and hallucinations. It is, indeed, the fountainhead of all creative activity (Boernstein[8, 9]). On

*The readiness and intensity with which a subject responds with a concrete image depends, among other factors, upon the psychosomatic "type" of the individual; more precisely upon the functional structure of its "sensu-tonus" (Boernstein, Refs. 4, 5, 6, 7).

this level "nothing has any significance . . . save what is given in tangible reality" (Cassirer,[10] p. 57).

Any "tangible reality," such as a concrete image, can serve as a symbol. While the patient is conscious of the symbol, she is only vaguely aware of the mental state it represents, or she is even totally unconscious of it. It is for this reason that the patient can provide a symbolic self-portrait without inhibition.

It was only the third question—"If you were an accomplished artist, how would you paint yourself?"—that opened the gates to concrete and involuntary "thinking." The first two questions had yielded no response. On the contrary, they produced such severe emotional tension as to block any fruitful reaction. Wherein does the difference lie?

The explanation is not difficult to find. The first two questions were a direct attack on a conscious level. This approach reinforced the patient's anxiety which, in turn, prevented any effective answer. The third question, however, called for an "as-if" situation. The factual attitude was replaced by a play-like attitude. Rational control was weakened and the motor-emotional factors were able to regain their original creative function.

In dreams, rational control is practically eliminated physiologically.* In the test-situation, the rational control is weakened psychologically. This is accomplished by asking the patient to conjure up an unreal situation. "*If* you were an accomplished artist, how *would* you paint yourself?" Even if the patient were actually an accomplished artist, she would still have to do her painting with words rather than a brush. The eagerness with which patients respond to the Verbal Self-Portrait Test indicates the effectiveness of its use of the play-and-dream attitude.

The analyst translates and interprets the symbols in the Verbal Self-Portrait exactly as he would interpret any dream. A Rorschach test, handwriting analysis, and drawing tests were independently administered by different testers to ascertain the validity of the writer's interpretation. The results were not only strikingly similar, but they also supplemented each other.

The Rorschach test** indicated ". . . she cuts off her emotions

*The cortico-thalamo-cortical circuit is largely eliminated and the ancient cortico-hypothalamo-cortical circuit comes to the fore in dream states (Boernstein, Refs. 2, 3). This change also characterizes the "uncinate state," as will be shown elsewhere.

**The Rorschach tests in all cases in this series were performed by Mrs. E. Sloman, New York City.

. . . She is afraid that her hostile feelings may come out in an uncontrolled way and make her lose her equilibrium . . . There is a conflict between 'wings in motion' and the 'body in rest,' immobilized. . . ."

These findings were supported by the handwriting analysis.* Here the tester found ". . . high flying enthusiasm . . . fear of losing the ground under her feet. . . . Her aims and ideas are almost suspended in a vacuum. . . . She does not dare to make a step forward, or has to stop suddenly in the middle of a step. . . ."

The drawing tests** furnished additional perspective, emphasizing "hostility against the male sex, castration wishes," with heavy undercurrents of guilt feelings and anxieties. Here again were revealed ". . . fear of expansion . . . fear of seeing things as they are . . . lack of insight. . . ." (See Figure 1.)

Figure 1

*The handwriting analyses in all cases in this series were performed by Mr. A. Kanfer, New York City.

**The drawing tests in all cases in this series were performed by this writer. The Circle-Triangle test and the Single Circle test (developed by this writer) and the Tree-House-Couple test (developed by this writer and also, independently, by other authors—see Boernstein, Ref. 11) were applied in each case. Only the Tree-House-Couple test is shown in the figures in this paper.

All these tests have one thing in common. They create situations in which the patients "project" their conflicts.* However, the Verbal Self-Portrait Test differs from other projective tests in several respects:

(1) It requires no special equipment. Thus it fulfills the cardinal prerequisite of projective tests that "the best projective responses are secured with the least elaborately structured or organized equipment" (Symonds,[14] p. 586).

(2) The tool used is speech—a simple but rich form of expression.

(3) The material used for projection is a part of the subject's own self, that part of himself which is a "tangible reality"—his body. By using his own physical being as material for the symbolic expression, his conflicts are brought closer to his consciousness, and are more readily felt as his own.

Figure 1 was drawn at the beginning of the patient's therapy. It shows her withdrawal from life and her lack of security.

The objects are floating in mid-air, unrelated to each other. The house, in particular, has no tie-in with its surroundings. There is no path leading to it. The empty windows suggest the patient's inner bleakness. The walls are partly broken.

The foliage of the tree is compact, concentric, turned in on itself. The patient is inactive, shuts herself off from the outside world, introjecting and involuting all her problems. The trunk of the tree is relatively frail.

The man and the woman are total strangers. They are in no way related. Yet, the woman's right arm ends in a dagger-like weapon which is pointed in the direction of the man's groin. Moreover, his sexual region is omitted in the drawing. Her castration wishes are thus evident.

Both figures stare into empty space. The absence of pupils in the eyes indicates that the patient is not able to see things as they are.

The Verbal Self-Portrait Test sets unconscious forces into motion. As an after-effect, it may lead to new "spontaneous" in-

*This conception of "projection" differs from that of such authors as Bellak (Ref. 12, pp. 12 ff.), who identifies "projection" with "the greatest degree of apperceptive distortion," and of Frenkel-Brunswik (Ref. 13, p. 393), who defines "projection" as "the ascribing to the environment of what is . . . unpleasant."

sights, thereby speeding up the psychotherapeutic process.* Patients themselves are often aware of this effect of the Verbal Self-Portrait Test. They frequently bring significant material to later sessions.

Several weeks after this test was given to the young woman, she remarked, "I had had the feeling that I had made stabs in the dark. Now, I am surprised how accurate they are."

Another patient stressed the therapeutic value of the test. "I think," she said, "we had a good session last time. It was stimulating. The discussion [on the Verbal Self-Portrait] helped to bring out things. In a sense, I had more objectivity toward the material that came out. I felt encouraged."

The remarks of a third patient were also revealing. "I liked the test. When you gave me the TAT test, I didn't get into it. I didn't enjoy it. It was unknown territory. It provoked anxiety. This new test cleared up conceptions I had had of myself. The test made them verbal. Before, I had had an inkling here, an inkling there. Now, I could bring them together. It helped me to realize my neurosis."

Ten months after taking the Verbal Self-Portrait Test, the first patient noticed that she was beginning to thaw out. "I let myself discover wider areas," she said. "Then I am tied down again."

Three weeks later she brought in the following dream: "I dreamed that I was here making a drawing. There were three figures in the picture, with graceful flowing robes and barefoot. I was especially pleased with the way I had drawn the feet. There were other people in the room, sitting beside me and drawing, too. Your wife examined the drawing, too, and she told us that we still needed some training."

Many changes are indicated by this dream. A positive transference has been established. Also, the patient is no longer paralyzed, "nailed to the floor." Instead, she can relax. In addition, she can now relate to others. Moreover, she recognizes that there is still work to be done. There was no doubt that she had made definite strides forward.

At this stage, in order to ascertain the reliability of the test, I again posed the query: "If you were an accomplished artist, how would you paint yourself?" This time she hesitated and groped for

*Here we see the same kind of process as characterizes the work of the creative thinker or artist—in which "intuition" leads to solving problems. (Boernstein, Refs. 8, 9.)

words. When they did come, they were punctuated by long pauses, perhaps 10 to 15 seconds. Some of her remarks were confused and repetitious.

"Well . . . I think I would paint myself if not exactly in motion at least with my eyes open. . . . At a window. Looking out."

"And?"

"Well . . . I suppose sitting on a chair. Or at the window. Looking out."

"Could you describe the painting in detail?"

"Well . . . Outside the window there is a street which is busy with people. . . . And the window is slightly raised from the street. And I am sitting, looking out."

"Which side of you is seen?"

". . . I think mostly my back. Or three-fourths of my back and my side."

"Where are you looking?"

"Down at the street. Toward my right."

"How much of you is seen in the painting?"

"Well . . . I'd say most of me is not in the painting."

"How about your arms?"

"Well . . . I think my arms are on the window. The elbows are on the window. And I am leaning on my hands. I am leaning forward. Out of the window."

"What other parts of the body can be seen?"

"The rest of my body down to the feet which are on the floor."

"Colors?"

"Yes. A lot of yellow, I think. And . . ."

"And what?"

"I think green outside on the street. The blouse is yellow, I think."

"What kind of weather?"

"It is pleasant. Summer."

"What time of the day is it?"

"Afternoon."

"Is the sun shining?"

"I don't know. I don't think so."

"What is the general mood of the painting?"

"Well . . . It is generally cheerful. But it may also be a little wistful."

In a state of flux, the patient wavers to and fro. Even in simple details, she does not know her own mind. She is constantly hedging, as indicated by her use of "Well . . .," "I think," or "I suppose."

The same may be said for her feelings. Still at odds with her true self, she does not trust the glimpses she has of her real emotions. Now more aware of her mental state, she has become more uncertain. She repeats the same words over and over because she has no faith in her ability to say what she means.

She is still so removed from people that she turns her back on the onlooker. This also illustrates her deep-seated uncertainty. She cannot look at people who look at her. But she herself can look at people if she is unobserved. In other words, she is not yet able to establish easy contact with others, but is interested in them. She looks toward the right. This fact is particularly noteworthy since the Right, at least in our culture, symbolizes the Future.*

Her feet are no longer nailed to the floor. She is comfortably seated. There are colors in the picture, which show clearly the change in her emotional state. In the first test she wore a dark blue blouse. Now she chooses a yellow one. The turning toward light colors presages a gradual awakening. All in all, the movement is toward life, toward the future.

Her handwriting at this time showed the same degree of progress. The graphologist found ". . . more self-control, composure . . . more zest for life . . . more objective attitude toward people . . . Yet, there is still some restlessness. . . ."

The drawing tests revealed ". . . turning toward men with outstretched hand . . . better contact with the world . . . more insight . . . over-emphasis on intellectual control . . . still castration tendencies." (See Figure 2.)

Figure 2, which was drawn 10 months after Figure 1, indicates some progress.

The house is curtained and looks inhabited. But this is a façade, because only the front can be seen. There is still no pathway to the world, and no foundation as yet.

But at least there is a reaching out for contact with others. The foliage on the tree has opened, even though the crown is partly cut off.

*Though this comment does not apply here, it is well to remember that there are other meanings too to the concept "right," such as morally right.

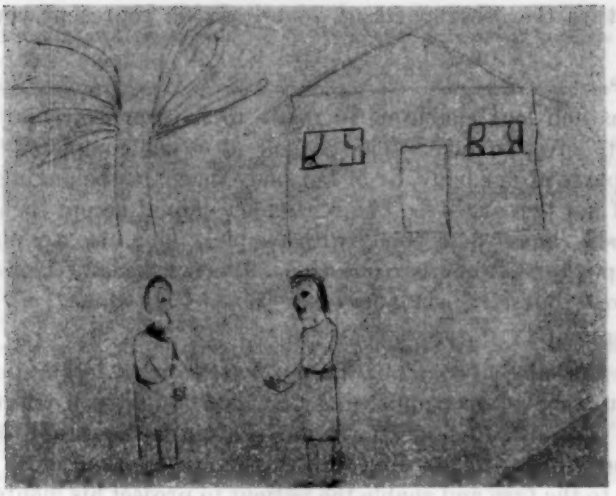

Figure 2

While not in close contact with each other, the man and woman are facing one another, each with an outstretched arm. The woman's dagger-like weapon is gone and there is a hand instead. But the sexual region and the feet are still missing in the man, and the man and woman have only one complete arm each. There is now a belt on the woman's dress.

The man and woman do not stare blankly into space. They look at each other, indicating awareness of each other's presence.

Another Rorschach test was not given. Instead, a new test-question was asked: *"Which part of your body represents your self most?"**

After a pause of about a minute, the patient found an answer. "Well . . . I think all of me. Except perhaps my arms and legs."

"What do you mean by that?"

"I feel that the rest of my body is my self. Except my arms and my legs."

"Your arms and legs are not quite so representative of your real self?"

"No."

*This question is called by this writer the "somatic ego-representation" test. It attempts to find out where the representation of the personality in the body-image is focused. The answers given by different individuals are manifold and significant.

"But all the other parts of your body do represent your real self?"

"Yes."

Arms and legs enable us to relate to the world around us—to walk, to give, to take. The patient does not completely accept these parts of her body, or of her body-image, as belonging to the core of her personality. The reason she cannot accept them is because she cannot deal freely with people. This also accounts for her reply to still another question. When asked, "When do you feel most yourself?" she answered "When I am alone."

To sum up:

The Verbal Self-Portrait Test is based on a simple question: "If you were an accomplished artist, how would you paint yourself?" Through this question an as-if situation is established. It has the effect of loosening rational control. Emotional forces spring to the fore and enable the patient to project his mental state in concrete images. He does this with the same abandonment that characterizes the child at play, the dreamer, or the creative artist or scientist at work.

The test question prompts the patient to project his mental state onto his body-image, onto a part of himself. In this way, his conflicts are brought nearer to the surface of his consciousness, and are more readily acceptable to him, than is true in other projective tests. Thus, the Verbal Self-Portrait Test is not only of diagnostic value, but it also acts as a therapeutic tool.

NOTE

This is the first of a series of papers on the Verbal Self-Portrait Test. The second has been accepted for publication in this journal.

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THE USE OF THE RORSCHACH TEST IN SCHIZOPHRENIA

BY ROY M. WHITMAN, M. D.

A. Background

The history of "schizophrenia" is older than the history of the Rorschach ink blot test but not by very much. In 1860, the Belgian psychiatrist, Morel,[1] first used the term "dementia *précoce.*" In 1863 Kahlbaum first used the term "catatonia," and in 1871, Hecker supplied the term "hebephrenia." In 1896, Kraepelin[2] put these together with the syndromes of the paranoid conditions into the syndrome, "dementia præcox." Bleuler,[3] in 1911, introduced the term "schizophrenia," not to mean a split in personality between affect and idea as is commonly thought in American psychiatry, but to identify what he thought was the primary process of schizophrenia, the loosening of the associational links in thinking. The affect-disturbance is secondary to this primary process. Bleuler is careful to use *The Group of Schizophrenias* as a subheading to his book, *Dementia Præcox.* His textbook still stands as a model for the description of this disease, although there are several other landmarks that should be mentioned. In 1911, Freud[4] described the Schreber case in which the psychodynamics of paranoia were first outlined. Storch's book[5] in 1924, together with the papers of Sullivan[6, 7] from Sheppard and Enoch Pratt Hospital, find their culmination in the later formulated writings of Federn,[8] Rosen,[9] Fromm-Reichmann,[10, 11] and the masterful exposition of a single case by Madame Sechehaye,[12] *Symbolic Realization.*

The history of the Rorschach experiment is equally well known and if we actually look back far enough to Kerner's book, *Kleck-siographen,*[13] we find that this date, 1857, actually precedes Morel's description of "dementia *précoce.*" Though we may mention Binet and Whipple[13] in passing, the real use of inkblots as a method of personality investigation begins, of course, with Herman Rorschach[14] with the publication of his monograph, *Psychodiagnostik* in 1921. It may be noted parenthetically that the year 1911 in which Rorschach first began his work with the inkblots was the same year as the publication of Bleuler's monograph on the "group of schizophrenias."

In *Psychodiagnostik,* there were investigations on schizophrenia which Rorschach had collected in the course of his work at various

institutions at which he was a clinical psychiatrist. The mantle was in a sense handed down to Emil Oberholzer, a medical psychoanalyst, after Rorschach's death. The first American trained in the use of the Rorschach was David Levy, a psychoanalyst, who worked with children. Samuel J. Beck, following Levy and Oberholzer, became the first American psychologist to work with the Rorschach method.

This history is important for the study of schizophrenia by use of the Rorschach (i. e., the group of schizophrenias for which the inclusive term, schizophrenia, will henceforward be used in this paper). The Rorschach test, though beginning in a medical setting, has in recent years become almost exclusively the possession of the clinical psychologist. Some clinical psychologists have, in Rorschach's terms, gone and gotten the experience necessary to use this as a clinical tool. Certainly Beck's classic work[15] in his book *Personality Structure in Schizophrenia* is an exception to any criticism leveled at the clinical psychologist for failing to have the prerequisite clinical background.

However, the psychoses have remained the province of the psychiatrist, although the area of the neuroses has been invaded by the psychological counselor. The psychologist has brought to the neuroses the insight of the Rorschach test. One may therefore, see an important reason why out of the 798 Rorschach references listed in the extensive bibliography in Bell's book[16] (mostly the product of clinical psychologists) only 29 of these concern schizophrenia, although this latter subject still remains the chief problem facing American psychiatry and the number one institutional health problem.

Nevertheless, other outstanding contributions to this problem, along with those of Beck[17] were made by Skalweit,[18] Hackfield,[18] Dimmick,[13] Benjamin,[19] and Rickers-Ovsiankina.[20] A standard Rorschach textbook[13] may be turned to for a summary of their excellent work, which has made a real contribution to the study of the thought processes in schizophrenia. That the Rorschach has made a major contribution to the concept of schizophrenia may be seen quite clearly from the Kasanin text[21] in which Beck's article (along with Cameron's) is, in this writer's opinion, the most lucid and penetrating.

B. Important Studies

The contributions of the foregoing writers often lumped together the various categories of schizophrenia, and their work has been hampered by the inadequacy of the psychiatric nosology. Some workers have attempted to use their own classifications—indeed Rorschach distinguishes four major schizophrenic categories, the well-preserved, the stereotyped, the scattered, and the simple. This is in contrast to other workers who have attempted to use the usual four psychiatric categories (i. e., simple, paranoid, hebephrenic and catatonic). Shakow's monograph[22] has lumped together all the schizophrenic groups, while Rapaport,[23] in his manual, has followed a new system of classification. In this context, Beck's phrase "schizophrenic solution"[17] is an improvement and reflects his clinical diagnostic caution.

With this as background, one can examine the various studies of schizophrenia and see the reason for the various discrepancies in results, although one might be led to think that there would be even greater variation than indeed there is. A complete listing of these may be found in Klopfer and Kelley's book,[13] with the discrepancies between various writers largely explained by the foregoing nosological difficulty as well as by some differences in scoring by various authors. Another area of discrepancy is the neglect of "phase"—acute, chronic, deteriorated, (Rapaport) to which Kendig[24] adds the post-schizophrenic (as contrasted with the pre-schizophrenic, also named by Rapaport).

Piotrowski[25] has a review of the three levels of Rorschach approach to schizophrenia. The first is that of the three well-known pathognomonic signs (i. e., contamination, marked variations in form level, and response determined by location and number). The second is the tabulation of ratios and percentages. These signs as used in a non-pattern approach are "linear" in approach; if they are used in a pattern and dynamic approach, Piotrowski labels this a two-dimensional approach. Finally he offers a three-dimensional approach consisting of the first two plus a consideration of the balancing factors of tension control as against tension-producing factors for which he utilizes primarily the shading responses and their nuances.

Nevertheless, there is no mechanical substitution for clinical experience and there must be a constant feedback from the clinician

to the Rorschach experimenter, and vice-versa, for real clinical acumen to develop. This is becoming increasingly more feasible and indeed necessary as the psychotherapeutic attack on schizophrenia increases in fury and efficiency. (See the following.[6-11, 26-29])

C. Limitations

1. *Modality of Response*

The Rorschach is a visuo-verbal test. Beck[30] expresses this simply, "If a person can see and talk, he can take the Rorschach Test." This would seem to include the populace between about age two and death who do not have impairment of those two modalities. This is a deceptively simple statement.

While Beck's paper in Kasanin's book seems to indicate that in schizophrenia there is no disturbance in perception *per se,* the question of the usefulness of expressive modality of speech and words is more crucial. There is no doubt that the schizophrenic often does not use words in the same way that the normal does.

There is an increasingly convincing body of psychoanalytic data that suggests that the most significant trauma experienced by the schizophrenic has occurred in the first year of life[26]—this would be at a time when the child is pre-verbal. Madame Sechehaye's book,[12] in which she finds that only concrete symbols are acceptable to the patient in terms of recovery, rather than words in the place of these concrete symbols, is extremely convincing along these lines.

Freud as quoted by Federn[8] states that sometimes words acquire reality values and sometimes facts shrink to mere empty words. This latter fact has led some writers to maintain the extreme position that the words used by schizophrenics are epiphenomenonal and are not related to the disease at all. Federn goes on to say that the well-known clinical fact that schizophrenic patients observe and even criticize events on the ward lends further credence to the fact that there is no failure in perception. Federn says that in verbal utterances of whatever sort, mostly secondary processes occur (with keen observations and correct judgment); but then, suddenly, primary psychotic mechanisms are employed with absurd combinations resulting. "Patients mix symbols with what is symbolized."

Some semanticists have gone so far as to say that schizophrenia is basically a disease of communication; and there is much to sup-

port the view that this disorder of communication is an outstanding manifestation of the disease, but little to support it as the primary mechanism.

But schizophrenia does seem to be a disturbance in the ego or self. As Mead[31] points out, the self is only constituted in terms of language behavior. It has been further suggested to the present writer that schizophrenia is a disease of the primary self,[32] i. e., the passive receiving self (me), rather than the active self (I). It is, of course, a contradiction if we say that the self cannot be constituted except in terms of language and then relegate this disturbance back to the passive receiving self, the oral receiving, preverbal stage of personality. But it is precisely this contradiction which makes the study of schizophrenia so difficult because we are in a sense studying a self that has been imperfectly constituted because of pre-verbal trauma, but can only be studied in terms of verbal symbols which are thus after the fact.

2. *Bipolar Theory of Perception*

Most of the early work on perception concerned the character of the stimulus. Psychologists of the Wundt and Tichener school used the subject as a high fidelity machine to record their experiments. The Gestalt psychologists set the stage for the importance of the perceiver; the Gestalt theories are extremely pertinent to the Rorschach Test.[33] Interestingly enough, Wertheimer, of the famed Gestaltist trio, worked several hundred miles from where Rorschach was working, and neither knew of the work of the other. (A disturbing precedent in this relation between psychology and psychiatry is hinted at in this fact.)

A huge amount of work[34] on the role of the perceiver in perception has led to the inevitable conclusion that a theory of perception must be bipolar.

Variations in stimuli must be between highly-structured or unstructured stimuli. A doorknob is perceived as such, no matter what the need-press of the perceiver. Conversely, completely unstructured stimuli such as a blank TAT card reveal such a variation in product that there is little hope of comparing different observations other than in an extremely subjective way. The Rorschach Test owes its usefulness to its falling midway between these extremes—at a point where the productions of the perceiver are

sufficiently altered by the stimulus as to aid comparison yet not so strictly ordered as to destroy variation.

The perceiver, too, may vary. Perception is essentially a function of the ego. On one side, there is the over-structuralized ego, where the blots are perceived as inkblots; and this is extreme reality attention despite its psychological meaning. Wendell Johnson[35] comments that a person at the peak of reality orientation would respond that these are inkblots. While this tells something about the person's character, it cannot be quarreled with as strict adherence to reality. The other extreme would be the person whose ego is so "damaged" that projection of meaningful percepts is impossible. Such a patient, as tested by this examiner, gave such responses as a "Spaulding tennis ball" or "Darwin's theory of evolution" when shown different Rorschach cards. These seem not to have been engendered by the blot stimulus at all.

There is, therefore, a minimum degree of reality-testing ego needed for the perceptual process to take place and, while this is sufficient for the vast majority of subjects, there are some "deteriorated" schizophrenics who do not meet this minimal criterion. They are unable to distinguish between external stimuli and stimuli arising from within.*

It would seem that there is a certain base line of ego development in schizophrenia. If this base line is laid down after the acquisition of meaningful language by the patient, then verbal tests are useful even in the most regressed phase. If the base line seems to be located before this acquisition of language, then such testing will be useless and such tests as the Rorschach will only be useful as the patient is regressing or recovering—in the pre-schizophrenic or post-schizophrenic stages.

3. *Nosology*

One of the great drawbacks in the investigation of schizophrenia is the failure of agreement of many investigators to decide just what schizophrenia is. Essentially descriptive and behavior diagnoses of schizophrenia are often made and there is a great difficulty in reconciling these to a perceptual diagnosis of schizophrenia.[37] Indeed, what a person sees is much more constant than what he

*Federn (Ref. 8) calls this the cosmic phase of the ego and it corresponds to the primary narcissism described by Freud (Ref. 36) when ego and nonego are not yet differentiated.

does. Despite the great variability in behavior patterns which are often not coincident with variation in perceptual pattern, the behavioral diagnosis of schizophrenia will undoubtedly continue to be used in psychiatry, because of the obvious social meanings of this in terms of hospitalization and legal responsibility. Rorschach's comments on the fact that the record of a manifest schizophrenic is often closer to normal than that of a latent schizophrenic are pertinent here.

We see that the Rorschach has the general disadvantage of only being able to predict potentialities for behavior and not actual predictable behavior in specific situations. This is an oft-criticized "deficiency" of the Rorschach made by clinicians, and it is accentuated by the fact that behavior is so pertinent in the category of this particular disease.

The foregoing discrepancy is one on a psychological level and does not even begin to go into the vast field of the differentiation in terms of nosology between the "organic" and the "psychogenic" forms of schizophrenia. Harry Stack Sullivan[6] was of the belief that dementia præcox should be called a disease with a basically organic substrate, while schizophrenia is a psychogenic disease.

D. Advantages

1. *Nature of the Test*

The standard advantages of the projective techniques as a test of personality are, of course, applicable to schizophrenics as well.[38] Specifically, the patient reveals his "private world"[39] without realizing that he is doing so. In addition, the interpersonal contact in proportion to the amount of material and information that is gained is held strictly to a minimum. Anyone who has dealt with extremely disturbed patients who will only tolerate short periods of interpersonal relations will recognize the value of this asset.

2. *Early Detection*

The outstanding clinical use of the Rorschach today aside from research value is its value in detecting the pre-schizophrenic process.[40] This term is perhaps more valuable than the more often used latent schizophrenia,[41] but both terms are pertinent. There has been a good deal of work, which has recently appeared in the literature,[26, 27, 42] concerning the treatment of the borderline states which is at variance with the usual psychoanalytic psychotherapy

of the psychoneurotic. The Rorschach can be invaluable in setting up and delimiting goals of therapy. Its use in mental hygiene, of course, follows from this, although, as a mass procedure, there are certainly many difficulties inherent in such an individualized test.

3. *Prognosis*

The Rorschach can also be used to determine improvement, treatability, and general prognosis of frank schizophrenic cases.[20, 43, 44, 45] It is crucial, however, to recognize that the therapeutic nihilism which was inherent in Kraepelin's original delimitation of the dementia præcox syndrome is no longer valid. He regarded the prognosis of deterioration as implicit in the diagnosis. The Rorschach test is an ideal psychological instrument to delineate and assist this change in orientation. For it is a dynamic test of personality and implies change and potentialities for change, and directions of personality shift; and it indicates areas most amenable to influence.

E. Future Research

Medicine has been almost overwhelmed by the appearance of the adrenal corticotropic hormone (ACTH)[46] and the description by Selye[47] of the diseases of adaptation. The relation between metabolism and perception has been investigated by several authors, but for the very reason of the schism between psychology and medicine there has been a great lag in this area. Certainly perception is one of the key mechanisms concerned in adaptation.

This area and the psychoanalytic investigation of schizophrenia are the two areas of research in schizophrenia in this country today which this examiner feels hold any hope of making a real contribution to the understanding of schizophrenia.

The writer is at present working on a Rorschach investigation of the effect of adrenalectomy[48] on the perceptions of schizophrenics. Certain work has suggested an intimate relationship between the syndrome of schizophrenia and adrenal function.[49] Preliminary studies suggest that the Rorschach category of Animal Movement (FM) is decreased when the adrenal and testicular glands are bilaterally resected. This would seem to be an example of a meeting place of two processes, biological instinctual impulses and psychological perceptual processes. The transactional processes between these two energy systems would seem to be a crucial area.

Hoskins[50] in his book, *The Biology of Schizophrenia,* has pointed out the levels of investigative organization, varying from the subatomic to the social, with all the degrees in between. Schizophrenia may operate or be initiated at any of those levels and there are many people who feel that an organic substrate will be eventually discovered. It is our job, however, to record the levels of behavioral organization as we are best able but with a careful eye to cross levels of integration. This cross-level correlation of observations at various levels or organization of the personality is fraught with many hazards and requires a freedom of communication between disciplines which is hardly being approached.

It might be mentioned that the Rorschach test is particularly applicable to the methods of patient-description suggested by Karl A. Menninger[51] at the meeting of the American Psychoanalytic Association in May 1951. He suggested a four-part description: (a) gross characteristics of the person (physical appearance, manner, etc.); (b) "part processes" (perception, intellection, emotion, and action); (c) integrated functioning (relations to self, relations to others and relations to things); (d) reaction to disintegrative threat (including normal reactions such as dreams, humor, etc., and emergency reactions).

Summary

The background and important studies of the use of the Rorschach in schizophrenia have been described. The Rorschach has made a valuable contribution to the reaction type known as schizophrenia. This has been largely in the nature of a description from a perceptual viewpoint of the thinking disturbance in this group of disease syndromes.

Some limitations of the Rorschach have been described which hamper its usefulness in certain phases of the disease, primarily the "deteriorated" or end phase. The first concerns difficulties in the modality of expression needed to communicate perceptual processes. The second is in the area of the ego function of perception which may be sufficiently affected by the disease process so as to make "perception" independent of external stimuli. The other limitation is that of the vague delineation of schizophrenia as an entity.

Some of the advantages of the test have been described. One consists of the nature of the test as a nonthreatening situation. Sec-

ond, the possibility of early detection of pre-schizophrenia and aid in goal setting and treatment outlines in psychotherapy is enhanced. And the third advantage would be in prognosis and measurement of improvement with a more consistent instrument than a clinical interview.

Some areas of future research have been mentioned concerning (a) cross-level correlations (e. g., perceptual and metabolic) and (b) personality description with an end to constructing an improved nosology based on an interdisciplinary approach to behavior deviances.

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A HOSPITAL PROGRAM FOR TEACHING AND SUPERVISING ADMINISTRATIVE PSYCHIATRY

BY FREDERIC G. WORDEN, M. D., AND JOHN D. PATTON, M. D.

I. Introduction

Experience as a staff member in a psychiatric teaching hospital is a fundamental part of the training of psychiatrists. In the last 50 years the emphasis in this experience has shifted more and more to the problem of keeping pace with the development of modern concepts of psychodynamics and their implications for psychotherapeutic techniques. The young psychiatrist of today leaves his mental hospital training much better equipped to understand behavior and to deal with it by the technique of interpretation than did his predecessor of 50 years ago. However, attendant upon this progress, there has been a certain loss, particularly in the area of administrative psychiatry and the use of authority as a technique in psychotherapy.

Fifty years ago the psychiatrist-in-training, neither overwhelmed nor overawed by complex psychodynamic theories, was more aware of the fact that a well-regulated hospital routine with good general care facilitated recovery for many patients. In situations where the meaning of behavior was quite obscure by modern standards, he learned that a realistic and just exercise of authority by the psychiatrist could serve a potent therapeutic function. At this empiric level he acquired judgment and skill in the use of authority despite the handicap of not knowing its implications in terms of present day knowledge.*

It seems to the writers that today the tables have been turned to some extent, so that now the young psychiatrist generally familiar with complex psychodynamic implications, may be rather inept

*The literature on ego psychology supplies a theoretical background for understanding the therapeutic value of clinical administration and authoritative activity by the psychotherapist. This literature will not be reviewed here except to mention Freud's paper, *Turnings in the Ways of Psychoanalytic Therapy*, which he read in September 1918. The question of activity by the psychoanalyst is discussed, and, with regard to the problem of analyzing phobic patients, he states: "With these last one succeeds only when one can induce them through the influence of the analysis to behave like the first class, that is, to go about alone and to struggle with their anxiety while they make the attempt." This first psychoanalytic paper on the problem has been followed by many subsequent works. Freud, Sigmund: Turnings in the ways of psychoanalytic therapy. Collected Papers, Vol. II. P. 392. Hogarth. London. 1946.

when a restrictive or permissive authoritative activity (in contrast to an interpretative activity) is required of him. This is particularly unfortunate, since so many patients encountered in a psychotherapeutic practice present degrees of ego regression or ego immaturity which seriously jeopardize the success of interpretative techniques unless those techniques are balanced by appropriate authoritative activities. For example, with young children, borderline psychoses. and severe character disorders the application by the physician of "ground rules" is at times more important than interpretation, not merely to protect the office furniture or the psychotherapist's physical well-being, but to support the threatened ego of the patient so that a psychotherapeutic process can ensue.

This paper will discuss some of the difficulties which beset the hospital teaching of administrative psychiatry and will describe a program in operation at the Sheppard and Enoch Pratt Hospital,* Towson, Md., which attempts to deal with them.

A training program such as this runs into the difficulty that physicians in training tend to develop misconceptions about administrative psychiatry which amount to a prejudice against it. By and large, applicants for hospital training plan to enter private practice and are not interested in a career in mental hospitals. Consequently they want to learn in the hospital those things which they think will be useful later in their practices. Most of them have recognized the value of knowing something of psychotic illnesses, something of mental hospital facilities, and, particularly, all they can about "psychotherapy."

But as for administrative psychiatry, most of them discover it for the first time when they arrive in the hospital and find some of the doctors are "administrators" and others are "psychotherapists." Out of this situation can develop the misconception that "administration" has little to do with "psychotherapy" and is merely a necessary evil, peculiar to the hospital organization, and absent from private practice.

Some features of the training experience in the hospital encourage this misconception. For one thing, the separation between "psychotherapy" and "administration" seems deceptively clear and definite. Some of the staff physicians have "psychotherapeutic" assignments in which the emphasis is on helping patients to "understand," while others have "administrative" assignments char-

*"Sheppard and Enoch Pratt Hospital" is abbreviated to "SEPH" hereafter.

acterized by the establishment of policies and issuance of orders. The young doctor's contacts with the supervisors of psychotherapy involve the prolonged and seductive intimacies of the apprentice-teacher relationship, whereas his encounters with the administrators are briefer and at times painfully abrupt. All of this can create an emotionally charged conviction that psychotherapy and administration are in two separate, if not incompatible, operational categories. Thus, what amounts to a division of labor in the hospital becomes misinterpreted as a reflection of the inherent nature and relationships of the processes called psychotherapy and administration.

Another pressure in the same direction is related to the impact which psychoanalysis has had on psychiatric training. It seems unnecessary to acknowledge the constructive effects of this influence, but it is pertinent to highlight certain pitfalls.

When the young psychiatrist turns to the literature on psychotherapy his readings are likely to be either psychoanalytic writings or publications in which psychoanalytic concepts are prominent. Yet, until recent years, the vast majority of psychoanalytic writings were based on experiences in treating patients who were not hospitalized. The problem of applying this scientific material to the treatment of hospitalized patients is just recently beginning to receive appropriate attention in print. Furthermore, the classic (and earlier) psychoanalytic writings were largely concerned with those aspects of clinical material relevant to the concepts of "id" and "super-ego." As psychoanalysis has moved on to studies of the ego and the role of the psychoanalyst as a participant in the "two person" relationship, its literature has become more difficult for the student to grasp and less "glamorous" to read. From a limited and selective reading in this vast psychoanalytic literature, the young psychiatrist often turns to his patients with an unfortunate ambition to be the completely permissive "mirror" in which the patient can see his "id" reflected. The mirror concept was used by Freud* in describing only one aspect of the psychoanalyst's role, an aspect which was in marked contrast to the commanding techniques of hypnosis. It is evident in Freud's clinical material that this "mirror" function was not intended to encompass his concept of the total activities of the analyst, and certainly it is

*Freud, Sigmund: Recommendations for physicians on the psychoanalytic method of treatment. Collected Papers, Vol. II. P. 331. Hogarth. London. 1912.

not so regarded by present-day psychoanalysts. In another publication,* one of the present writers has described a swing to "permissive" authoritarianism related to this misunderstanding, and has discussed some aspects of the role of authority in therapy with hospitalized patients. In the hospital setting, a young psychiatrist whose picture of therapy is limited to the "mirror" concept collides with administrators whose orders are felt sometimes as attacks on "The Therapy."

A further influence of psychoanalysis operates through the fact that psychiatrists in training in the hospital may also enter training in a psychoanalytic institute. The technique used by the student's training analyst acquires status as a model for therapy, in terms of which techniques that are different but necessary with hospitalized patients may be ignored or viewed with unjustified contempt. This is particularly true of the attitudes toward administrative factors, so that the potentially therapeutic effect of a well-regulated hospital on psychotic patients is overlooked or belittled. At best, this does not contribute to teamwork; and, at worst, it can stir up serious antagonisms between staff members.

The inherent nature of the doctor-patient relationship in psychotherapy is another pressure in the same direction as just described for the aspects of the hospital organization and the influence of psychoanalysis that have been noted. In intensive therapy with a psychotic patient, even an experienced therapist will make a heavier investment in his patient's needs than does the administrator, whose contact with the patient is more limited. Although this is as it should be, it does create some discrepancy between the therapist's view and the administrator's view. Moreover, with the less experienced therapist, an exaggerated investment in the patient inevitably occurs if the therapist shows any talent at all for psychotherapy, and this is attended by exaggeration of differences between the therapist and administrator. If this situation is not well managed the patient may be buffeted by a cross-fire of approval by the therapist and "squelching" by the administrator, as well as by the therapist's own pendulum swings from overpermissive to excessively restrictive attitudes. Under such conditions, the patient is unlikely to learn much about his own conflicts concerning "good"

*Worden, F. G.: Psychotherapeutic aspects of authority. Psychiatry, 14:1, 9, 1951.

and "bad" authoritative figures, since he is usually too busy trying to use the "good" administrator against the "bad" therapist, or vice versa.

Finally, but by no means without significance, there is the problem of the mechanics of hospital operations. Communication and co-ordination on a day-to-day (and, at times, minute-to-minute) basis among therapists, administrators and nurses is necessary, yet difficult. Situations arise on the wards in which the charge nurse has to obtain an immediate decision from the administrator and act upon it in the absence of the patient's psychotherapist. Unless this by-passing of the therapist is kept to a minimum, the latter's role with the patient will be seriously distorted. He becomes a powerless figure who may be available for talk but does not really have much to do with what is going on in the hospital. The therapeutic collaboration between the doctor and patient thus becomes blissfully free of "unpleasant" feelings or actions, which the patient is more than ready to relegate to his dealings with the "powers that be."

The therapist's isolation from the routine operation of the hospital is exploited, then, by the patient's (as well as the doctor's) anxiety lest these "unpleasant" topics disturb the therapeutic relationship. Thus, critical or resentful feelings of great psychodynamic importance may not be mentioned. "Why talk to him about it, he has nothing to do with it anyway?"

These remarks do not cover all of the factors which can create a breach between administrators and psychotherapists in a hospital. Although the authors of this paper are at present primarily psychotherapists, they are aware, from their own previous experience as hospital administrators, that "sore points" in staff functioning also reflect specific personal factors involving details of individual reactions by doctors, hospital personnel and patients in particular situations. However, this paper will confine itself to the more general sources of trouble just outlined, and will describe the attempt being made in this hospital (SEPH) to minimize them by a method of staff operation. Attention will be centered on the medical staff, so that the role of nurses can only be touched upon, although the nurse is a key figure in the daily interaction between the patient and the administrative forces of the hospital.

II. Staff Operation in the SEPH

The SEPH is a private, nonprofit psychiatric hospital of approximately 280 beds. All standard means of psychiatric treatment are available, but the primary emphasis is on psychotherapy. The patients are carried on two services, an "Active Treatment Service" which includes those who show some capacity to respond to intensive psychotherapy, and a "Continued Treatment Service" for patients who are unable to make use of intensive psychotherapy. Patients are shifted freely from one service to the other in accordance with changes in their clinical conditions.

The physicians in this hospital fall into two groups, a junior staff of 10 to 12 resident physicians in various states of training, and a senior staff which supervises and directs teaching, administrative and therapeutic activities. This medical staff is under the over-all direction of the medical director. An assistant medical director is directly responsible for administrative functions concerning the patients, and is assisted by a chief of the active service and a chief of the continued treatment service. The responsibility for teaching and supervising psychotherapy is assigned to a psychiatrist-in-chief assisted by the clinical director.*

The resident physicians are assigned as psychotherapists, each carrying a case load of 10 to 15 of the patients on the active treatment service. Also, each resident, in turn, is assigned to spend three months as an assistant to the chief of the continued treatment service, helping him to care for the continued treatment patients and to supervise the shock therapies, both electric and insulin.

This paper is specifically concerned with two problems in the administration of the active treatment service. One is the method by which the chief of the active service teaches and supervises the administrative activities of the resident physicians, and the other is the technique by which this is co-ordinated with the training and supervision of psychotherapy.

The harmonious operation of such a hospital organization is greatly influenced by the general feeling of the entire group of persons in the hospital. This general feeling which pervades the hos-

*The teaching and supervising of psychotherapy at the SEPH was described in "Participant Teaching of Psychotherapy by Senior Physicians: A Hospital Program and Clinical Illustrations." By Hill, L. B., and Worden, F. G. Psychiat. Quart., 26, 228-243, 1952.

pital might well be called the "atmosphere" of the hospital. If the senior medical staff is split by differences in perspective and resultant antagonisms, there will be unfavorable repercussions in the hospital atmosphere, analogous to the effect on a family of serious incompatibilities between parents. It is pertinent to mention that in the SEPH, the senior physicians, whose duties are primarily administrative, are also experienced psychotherapists. Similarly, those senior physicians whose duties are primarily psychotherapeutic have had experience as hospital administrators.

The chief of service, who deals directly with the resident physicians, also has time to carry a few patients in psychotherapy. Thus, although his role with the residents is administrative, his psychotherapeutic activities are known to them and serve as a reminder that he is not unfamiliar with the problems they face as psychotherapists. It appears to the writers that this experience of the senior staff in both psychotherapy and administration helps to prevent any gross difference of perspective in the various members about the relationships between psychotherapy and administration.

This general agreement in perspective includes an awareness that the adjective "administrative" refers to the *quality* of a process, whereas the adjective "psychotherapeutic" refers to the *effect* of a process. An administrative process is understood to mean one which takes the form of an action having a judicial aspect (making a decision) and an executive aspect (making a situation conform to the decision by managerial measures). This is very clear when a doctor transfers a patient from one ward to another, or restricts a patient's freedom to visit away from the hospital. However, when an analyst tells an analysand that an "hour" is 50 minutes, that there will be five appointments a week, that a couch will be used and that the analysand is to tell whatever comes to mind, the administrative quality of these activities may be obscured by the other techniques employed after this structure is imposed upon the analytic situation. It follows from this that an administrative process may be psychotherapeutic, psychonoxious, or, perhaps, may even have no important therapeutic implications, and it also follows that psychotherapy, in a hospital or in private practice, always requires administrative activities by the physician.

Thus, the customary division of labor in a hospital, between psychotherapeutic and administrative assignments, is one of degree and cannot ever be absolute. This means that a resident physician assigned to do psychotherapy is not thereby freed of participation in administrative psychiatry. Furthermore, the senior physicians, who make administrative decisions and supervise administrative work, must be aware of the possible meanings and effects of their decisions upon the hospital patients. The senior physicians who supervise psychotherapy must, likewise, be aware of the meanings, necessities for, and therapeutic usefulness of, administrative decisions.

This raises the questions of the extent and nature of the administrative role of the resident and of how best to teach and supervise him in the acquisition of skill in this area. Since he is likely to encounter administrative problems as soon as he meets his patients, the training program must start promptly and must continue in a fashion consistent with the needs of running the hospital, as well as with the needs of the resident and his patients. Elements of such a program, which have seemed useful in this hospital, will be described. These include a mimeographed administrative "guide" for new residents, administrative meetings for residents, and the techniques for staff communication and coordination.

III. Co-ordination of Psychotherapeutic and Administrative Functions

A. *Guide for Residents*

An administrative "guide" is furnished to new residents upon their assumption of duties at the hospital. In the first few days of their hospital experience, they are oriented as thoroughly as possible through the use of lectures, discussions, and individual conferences. The "guide" serves as a frame of reference for this administrative orientation. In it, there is a brief discussion and clarification of the meaning of, and relationship between, psychotherapy and administration. Administrative procedures are divided into two large categories. One comprises those aimed primarily at meeting the over-all needs of running the hospital in conformity with the requirements of the patients as a group, as well as with financial, legal and efficiency factors. The second category is made up of procedures aimed primarily at the needs of an indi-

vidual patient. It is emphasized that for effective individual treatment of a patient, the resident physician must have an informed and responsible awareness of both categories. With such an awareness, the resident (having the most intimate knowledge of the patient) becomes a key figure in adapting and utilizing administrative policies most effectively for each individual patient.

It is pointed out that the first category of administrative procedures (those geared to the general needs of the hospital) serves as a powerful influence on the patient. Although the individual patient reacts to these influences in accordance with his own personality pattern, the result is usually psychotherapeutic. The importance of recognizing the useful effect of the orderly and regulated routine of the hospital is stressed. It is pointed out, as a "rule of thumb," that patients will see, in the general policies of the hospital, what they need to see to enable them to communicate their underlying conflicts. The hospital may elicit feelings about "injustice," which the patient never dared express toward parental figures in childhood. It is suggested that, if he is to be useful to the patient, the resident must, with firm but just consideration for the patient, pursue with him the meaning of such attitudes. The resident is cautioned that patients may be very skillful in finding actual evidences of "injustice" in the hospital, but that the dynamic and genetic meaning of "injustice" as an issue in the patient's life must be the main goal of therapy, rather than administrative efforts to eliminate injustice from the hospital scene. If the resident physician can comfortably accept the realistic imperfections in the hospital, he will be free to deal therapeutically with patients who see nothing but fault in the hospital, as well as those who can see nothing but perfection.

The second category of administrative procedures (those aimed at the needs of an individual patient) is pointed out as generally more flexible and available for utilization by the resident physician as part of his therapeutic activities. His responsibility for using these to meet safety requirements, such as taking precautions against suicide, is described; but the potential therapeutic effect of administrative procedures is also explained. For example, it is pointed out that being "busy" on an open ward can represent a gain by the patient, but it may, on the contrary, represent a means by which the patient strives to avoid learning anything about himself at all. It is suggested that, in the latter case, transferring the

patient to a closed ward might serve a psychotherapeutic function. The use of a transfer to a more open ward as an attempt to placate the patient is contrasted with a properly-timed transfer, which furthers psychotherapy.

The "guide" also includes a rather detailed list of specific administrative problems and the local policies in reference to them. The resident's responsibility is delineated for each item, whether the decision rests entirely with him, or entirely with the chief of service, or whether it is a staff decision initiated by the resident for approval by the chief of service. The list will not be reproduced in detail, as much of it reflects local conditions in the SEPH. However, some of the items reflect factors common to all hospitals. These include suicide and escape observation, seclusion, all types of parole and special privileges, visiting or transfer from ward to ward, visits away from the hospital, and visitors from outside the hospital.

The resident physicians are delegated responsibility for dealing with the relatives and friends of their patients, including telephone calls, correspondence and personal interviews. The chief of service supervises these activities and is available to assist the resident if he gets into difficulty. This responsibility is mentioned because of its importance in keeping the resident informed about the financial, legal and personal pressures of the patient's life situation so that treatment plans may be kept more in conformity with these realistic factors.

B. *Administrative Meetings for Residents*

The main task of teaching and supervising the administrative activities of the resident physician proceeds by way of a daily half-hour "Administrative Meeting for Residents" which is conducted by the chief of service. These meetings are held immediately after lunch so that all participants have had an opportunity during the morning to acquaint themselves with the developments of the day in the hospital. In the writers' experience, these relatively short, but daily, meetings permit better communication and co-ordination than do longer but less frequent meetings.

The form of these meetings is similar to that of the psychotherapeutic "round" meetings with the supervisors of psychotherapy.* The chief of service presents to the residents whatever business he

*See Hill and Worden (footnote, page 43).

has. This usually involves administrative procedures related to general housekeeping needs of the hospital, such as transfers which may be necessary to make beds available for new admissions. He may also bring up problems about individual patients where the resident physician has not been "on the ball," such as the problem of transfer of a disturbed patient to a closed ward. As far as possible he presents the reasons for decisions in cases involving residents, perhaps calling attention to factors which the resident may have overlooked. The residents have an opportunity, in turn, to bring up their business with the chief of service. This includes recommending administrative actions appropriate to the needs of individual patients, as well as giving information about the patients which might be pertinent to the duties of the chief of service. An outstanding difference from the therapeutic "rounds" lies in the fact that the emphasis is on getting things done and the discussion is more on a conscious, intellectual level. If emotional or unconscious factors in the resident obtrude, an effort is made to "talk them out," but usually a prompt decision is necessary and, if differences of opinion persist, the chief of service must settle them by authoritative decisions. Even if the chief of service has a comfortable acceptance of this administrative responsibility, there are occasions when emotional tensions between him and the resident physician persist. In order that such tensions may best be resolved, the chief of service sits in on therapeutic "rounds" meetings and can participate there in a seminar type of "airing" of various aspects of the problem. Such tensions may also be dealt with in individual meetings between the chief of service and the resident. It is worth noting that the supervisors of psychotherapy do not sit in on the administrative meetings because the practical necessity of getting things done forbids the type of psychodynamic discussion which would be the main advantage of their participation.

C. *Contacts with the Chief of Service Outside the Daily Meetings*

The chief of service has an office in a central location and tries to be available for consultation with the residents at all times. From time to time, he reviews with each resident the administrative problems pertinent to the resident's case load. This provides an opportunity to discover and bring to the resident's attention recurrent patterns of administrative difficulties which may be impeding his work.

D. *Participation in "Rounds" by the Chief of Service*

As previously mentioned, one important aspect of attendance by the chief of service in the therapeutic "rounds" meeting is to afford an "airing" of emotional tensions related to administrative actions. Another advantage is that it provides information about the progress and goals of psychotherapy which assists the chief of service in adapting his administrative activities to psychotherapeutic considerations. Furthermore, his presence in "rounds" helps to keep him and the supervisors of psychotherapy in step. This is particularly important in situations where a resident may tend to play one authoritative figure against another, perhaps by the use of misleading quotations from the chief of service during his presentations to the supervisors of psychotherapy. To consolidate the senior staff approach further, there are weekly meetings between the chief of service and the supervisors of psychotherapy for the purpose of discussing clinical and training problems.

IV. Practical Operation of Training System

To illustrate the practical operation of this system, a composite picture of some experiences with it will be reviewed in terms of a hypothetical resident physician dealing with a hypothetical patient. This will permit a briefer presentation and will avoid any necessity for the invasion of privacy which would be involved in a more detailed account of experiences with an individual resident physician.

Physicians entering hospital training fall into two general groups with regard to their attitudes toward administrative procedures, those who are overpermissive and those who are overrestrictive. In general, pendulum-swings back and forth between these two attitudes occur as the physician proceeds through his training experience. Going through these pendulum-swings in the course of treating a variety of patients culminates gradually in the acquisition of a more balanced and skillful administrative capacity.

To begin with, some problems will be described which are presented by an overpermissive resident assigned to work with a borderline psychotic patient of the type who relies heavily on manipulative techniques. Characteristically, a mutually laudatory "good fellowship" relationship develops between the doctor and the patient. This is nourished by a barter in which the patient presents "psychodynamic" material pleasing to the doctor in exchange for

placatory tokens from the doctor which pass as "understanding." These tokens may take the form of unnecessary sedation or special diets, or efforts by the physician to get the nurses to give "special" attention to the patient. As these demands inevitably increase, they come to the attention of the chief of service, either through reports from the nurses or through direct requests by the resident that the chief of service approve extra activities and freedoms for the patient. In therapeutic rounds, the supervisors of psychotherapy hear from patient and doctor alike that everything is going fine and great "progress" is being made.

The problems presented by this ripening situation, for the various individuals involved, constitute a complicated group interaction out of which a teaching and therapeutic process must, hopefully, emerge. For the nurse, this becomes a potentially exasperating ward problem, with the demands of the patient backed up by the resident, and the jealous competition of other patients disturbing her sense of fair play. This situation is exasperating not only on the ward, but also because it creates the necessity for appealing to the chief of service for help "against" the resident. The supervisors of psychotherapy must consider the therapeutic needs of the patient, the requirement to keep the problem within the administrative tolerance of good ward and hospital operation, and the therapeutic and pedagogic needs of the resident physician. For his part, the resident is confronted with increasing demands from the patient which threaten to get him into conflict with the nurses or the chief of service or, if he fails to meet them, with the patient; and, at the same time, his security with the supervisors of psychotherapy is shaken by a growing awareness that his efforts are not accepted as "therapy" in the sense he had hoped. As to the patient, he is confronted not only with those inner anxieties which motivate his manipulative defenses but also with the repercussions in other persons secondary to his success in exploiting the resident and achieving a "favored child" role on the ward.

The problems arising from an interpersonal constellation of this type have to be dealt with by a well co-ordinated and properly-timed response of the hospital program, rather than by independent and piecemeal interventions by the supervisors of psychotherapy and the administrators. In the therapeutic "rounds" seminars, efforts to clarify and work through the pertinent anxieties in the therapist and patient proceed in the presence of the chief of serv-

ice, who documents the morale problems of the nurses and of the other patients on the ward. This helps the resident to see some of the effects of his relationship with the patient on the social milieu of the ward and hospital. If he sees that the entire ward is up in arms against his "favored" patient, he gets a new perspective on his therapeutic activities and he is better prepared for decisions by the chief of service which conflict with his administrative recommendations.

In the administrative meetings, the chief of service attempts, as far as possible, to keep his decisions geared to the pace of "working through," which he has seen occurring in the resident in the therapeutic rounds meetings. Administrative requests by the resident, which seem more appropriate to the resident's anxieties than the patient's needs, may be approved in terms of a recognition that "mistakes" which the resident is insistent on making can become fruitful learning experiences for him. Such permitted "mistakes" are, of course, restricted to situations in which neither the patient nor the welfare of the hospital is jeopardized.

For example, despite his experiences in the therapeutic "rounds" seminars and in the administrative meetings, the resident may persist in advocating an inappropriate transfer of a patient to an "open" ward. Perhaps his hope is that by such a reward he can encourage the patient to recover (that is, be "good"). On the open ward the patient then begins to act out to an intolerable degree his feeling that everyone in the hospital is "bad" except the "good" therapist. This can induce a profound change in the therapist, related not only to the disappointment of his therapeutic hopes, but also to the fact that he himself begins to feel this acting out as a personal attack on himself. His excessively permissive approach to the "good" patient is replaced by a vindictively restrictive response to the newly-discovered "badness" of his patient. Here again, the resident uses administrative procedures to express his feelings. His recommendations are now along the line of requests that the patient be locked up on the disturbed ward, that no attention be given by ward personnel to the patient's requests, that no medications be given for minor physical complaints, even though there might be valid medical indications, and that the patient be excluded from recreational activities. His therapeutic enthusiasm has been replaced by punitive and nihilistic attitudes. Usually, of course, the punitive nature of these actions is concealed by ration-

alizations to the effect that the patient is too sick to be given freedoms, or that he is so spoiled that his requests should be ignored, or that he needs to express hostility, and that systematic neglect will help him to do so. Sometimes the doctor frankly states his feeling that the patient is a "no good psychopath" who cannot use, and does not deserve, psychotherapy.

Here, the supervisors of psychotherapy and the chief of service must respond with a collaborative effort, not only to protect the patient from this attack, but also to help the resident in seeing what feelings he now has and what reference they have to his former feelings about the patient. The chief of service must evaluate the ward reports and the patient's condition. He may either leave the patient on the open ward or return him to an appropriate closed ward. Rarely does the chief of service find the patient's condition as "bad" as represented by the resident. Sometimes the chief of service may have to initiate and urge increased freedom or activity for the patient because the resident is still resentfully reluctant to institute appropriate actions. As before, these administrative processes are brought into conjunction with the therapeutic "rounds" discussions by the chief of service and the supervisors of psychotherapy.

There are, of course, innumerable other possibilities. If a request by the resident is disapproved by the chief of service, the resident may join the patient in a bitter commiseration about the cruelties of administrators. Sometimes the resident will use the supervisors of psychotherapy against the chief of service, by misquoting or partial quoting of opinions which may have been offered during a single counseling appointment. Similarly, opinions voiced by the administrator can be misused by the resident in dealing with the supervisors of psychotherapy.

As can be seen, all of these problems have both psychodynamic and administrative significance and cannot be effectively managed except by a program, such as that described here, which permits all members of the staff team to see all sides of the complex total picture. Even with these techniques for co-ordination and communication, the actual hospital operation is characterized by frequent stressful difficulties. This illustration has been simplified to highlight techniques of operation and not to imply that this, or any other, system is a panacea.

V. Summary and Conclusion

Techniques which are essentially administrative are important in psychotherapy, whether in a hospital or in private practice. A tendency to develop prejudices against administrative psychiatry often occurs in physicians during their training period in psychiatric hospitals. Some of the sources of this prejudice have been mentioned. A program for teaching and supervising the training of psychiatrists in a hospital has been described. The essential features of this program are the methods for co-ordination of the administrative and psychotherapeutic operations of the hospital staff. The importance of making the physician-in-training a responsible participant in the administrative chain of command is emphasized, and some experiences are reported to illustrate problems involved in doing this.

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REPORT ON FURTHER DEVELOPMENTS IN GROUP PSYCHOTHERAPY ON A CHRONIC SERVICE OF A MENTAL HOSPITAL

BY GERDA WILLNER, M. D.

Introduction

Since starting group psychotherapy on a chronic mental hospital service in May of 1951 (as reported in The Psychiatric Quarterly Supplement, Part 1, 1952) the writer has found it necessary to make a few changes concerning the size and composition of the group, the location and duration of the meeting, and the technique used. Also, there have been modifications in the goals she set for herself in this therapeutic endeavor. Certain advantages, disadvantages, limitations and dangers of group psychotherapy came into clear relief.

The writer will give a brief account of several important features of group psychotherapy with special reference to its application at Central Islip State Hospital. In addition, she will point out the changes which occurred since the introduction of this sort of therapy on this particular service. Excerpts will be given from stenographic reports of patients' reactions to the features discussed.

The Group

While starting out with large and heterogeneous groups of 25 to 30 female patients, the writer found indications that it would be preferable to restrict the size of groups to not more than 10 patients. A group of 10 is large enough to represent a community and yet small enough to allow the therapist to know the individual group members intimately, to study their reactions closely, and to make the patients feel that they are one single, large family.

The grouping was done from the vantage point of level of intelligence and degree of preservation of personality rather than of diagnosis. The best results were obtained with fairly intelligent convalescent patients, incipient schizophrenics, pseudoneurotic schizophrenics, psychoneurotics, and manic-depressive patients in the free interval period. Important for the selection of the group members were the following: that each express the wish to be helped; that they show a tendency to socialize; that they do not resent the therapist or feel that the invitation to participate in the

group is coercion. Patients who are frankly depressed, excited, aggressive, or hostile, have to be excluded from the group, even though they may have started to participate in group psychotherapy during relatively quiet intervals. Open outbursts of hostility and aggression during the group meetings were found to be detrimental to the group spirit, because they increased latent anxiety and hostility in the other group members.

Smaller groups formed little families from the very first session —with very good doctor-patient and interpatient relationships. With a few exceptions, the group spirit continued to be most cooperative and amicable from the very beginning. The larger groups, however, had shown a tendency to premature disintegration because of too great differences in the members' levels of intelligence, in the preservation of personalities, or in the stage of progression of mental disorder. Hostility, competitiveness, loss of interest, and the development of a sort of jungle philosophy, which one finds side by side with crowd-minded behavior and mass reactions, were the results. For instance, a large group of 30 patients would make a dash for the cigarettes and magazines spread out for the group on the center table, and actual fights would ensue. The therapist could not help but feel that some of the patients were more interested in obtaining cigarettes than in participating in the therapeutic procedure. The physically strongest patient got the most. The aggression and competition was infectious; the participation of the entire group in this action seemed to sanction the behavior of the single group member. Later on, the same trouble-making individual within a small group would actually behave in a perfectly civilized manner.

Certain members of the larger groups also made irrational claims on the therapist and the other group members with increasing frequency. They would try to dominate the conversation and to overshadow the less spontaneous members. They tried to use the therapist and the patients for their own neurotic and psychotic goals. They would crave the therapist's love and become jealous and hostile when confronted with the fact that 29 other group members had equal claims on the therapist's time and attention. The smaller groups were less competitive and much more democratic in behavior.

The large groups required strong leadership and called forth authoritative behavior by the therapist, with stress on the didactic

approach such as lecturing, reading from books, and presentations of theses from the side of the participants. Only very superficial discussions of large general topics with little analytically-inclined therapeutic implications were possible in the large groups. In addition to all this, it was difficult to give these groups continuity and direction in the democratic way of life.

The members of smaller groups acted more spontaneously, brought up intimate personal problems, and were interested in the individual case histories of the other participants. There was less competition in trying to gain the favor of the therapist, although some reactions of this sort were still noticeable. The members of the smaller groups related themselves more intimately to the therapist and to each other; and if hostility gained the upper hand in one of the patients, the others would take a firm stand against the erring group member!

Here in the smaller group the therapist does not have to be the leader and organizer but can retreat to the role of a moderator and to that of an unobserved but always interested and alert spectator. This writer maintains that it is more stimulating to have patients with various types of mental diseases and various character structures grouped together. In this way it is easier to bring a variety of problems into the open than by working with more nearly-like types of patients, when some types of problem would be unanimously repressed or overlooked. Similar character types such as predominantly aggressive, compliant or detached patients, or similarity in the psychosis of the majority of the members would lead to focusing on the common problems, would bring these problems into clearer relief and would lead to resolving these conflicts much faster. But this would also bring about a certain monotony in the choice of topics and a dwindling of interest by the group members. Diversity in the pre-psychotic personality make-up, in the type of illness, in the age level and civil status of the members, has proved to be favorable for group psychotherapy!

As to the frequency and duration of the single sessions, the patients were told that they were allowed to draw sketches, to read poetry or excerpts from articles of their own choosing for half an hour or even longer after the sessions—a procedure which brought the duration of each meeting to one and one-half to two hours. Due to lack of time and administrative difficulties, each

group meets once a week only but attempts will be made to have semi-weekly meetings for each of the groups.

The little group of 10 was delighted when the therapist took them from the large day room in which the sessions had usually been held to the little intimate playroom in the basement of the building where they settled down around the ping-pong table and made no attempt to fight for candy, newspapers, and cigarettes as they had done previously. (Each knew that there would be plenty left for each member today.) Let us now hear their reaction to the change of size, composition, and location of the group.

STENOGRAPHIC EXCERPTS FROM THE GROUP DISCUSSION

Adrienne C.: "I like it so much better down here, doctor. It is much quieter and cozier here and I'm so glad that Audrey is not here anymore to interrupt me with her sex talk and murder stories!" (Audrey is a very paranoid and hostile schizophrenic patient who tried to change every topic to one of her own choosing—usually one with sinister moral implications.)

Beatrice H.: "Now we are a regular little family, only 10 girls. My grandmother had 16 children."

Christine W.: "I like large groups so much better. I get more out of it if lots of people are talking. Everybody has different problems. Here we all seem to have the same problem."

Beatrice H.: "How can you say that, Christine. Look at your own problem. None of us has trouble like you. I should think that you would prefer to have less people listening to you." (Christine is a chronic alcoholic.)

Anna A.: "If there are less people you can talk more freely and much longer. I can talk better if certain people are not here."

Adrienne C.: "Like Audrey, for instance. Today I got much more of your attention, doctor. You actually let me talk without stopping me and calling up somebody else. And you had time to make many more comments and to give your opinion about everything I was saying."

Ruth F.: "I like large groups better. There the mind wanders more freely. Today I had to stick to the topic. My mind likes to wander even if my body has to be here in this room. It's much more interesting if your mind is allowed to roam about. But perhaps you like it better this way, doctor, though you have to pay so much attention today to what everybody is saying. In the larger group, I did not even care to listen sometimes because so many were talking together at the same time and I could not understand what they were saying anyway."

The Therapist; Doctor-Patient Relationships; Transference Reactions

In order to speak of group psychotherapy, it is assumed that the person conducting the meetings is psychiatrically trained. At Central Islip State Hospital, comparatively small groups are conducted by psychiatrists, larger and more heterogeneous groups are conducted by social workers, and a few selected groups of various sizes are conducted by specially trained nurses who have as their main goal the mental and physical re-education of certain types of patients, such as lobotomized patients and seniles with arteriosclerotic brain damage who are recovering from apoplectic attacks with resulting aphasia and paresis.

The physician in charge of the group meetings should be a competent psychiatrist with his own philosophy of life (*Anschauung*) who will enter wholeheartedly into the therapeutic undertaking, which means giving undivided attention, being on the alert all the time, taking an active part in the discussion if necessary, and letting the patients have no doubt as to the sincerity and soundness of the therapist's character and morals. In addition, he must have great flexibility, presence of mind, and the ability to make quick decisions.

The therapist should endeavor to offer his patients the help of a sound human being, and by displaying the soundest possible behavior, he will automatically confront his patients with the absurdity and unreality of their delusional ideas. This writer found the fact that she had started her own personal psychoanalysis to be extremely helpful in the way of remaining calm and unruffled by flattering or offensive remarks and unswayed by contradictions and unreasonable demands of the group. Being psychoanalyzed helps the therapist to resist the formation of counter-transference, and no serious personal problems will interfere with the therapeutic procedure. Experience is valuable but not absolutely necessary. Young resident psychiatrists are sometimes able to do an excellent job in their first attempt at group psychotherapy, for there is no blueprint to guide one in the line of approach to mentally sick and disturbed patients. For in addition to giving his patients a chance for catharsis, intellectual clarification of his problems, stimulation and re-education, the doctor has to give his patients general human help!

The position of the conductor of the group was interpreted by the patients as that of a parental figure, a big sister, a cousin, or a friend. Great care was taken that the therapist should not be viewed as an irrational tyrannical authority. As the strength of the group increased, the therapist's authority diminished rapidly, and she receded completely into the background, acting merely as a moderator or interested spectator. Here is the response of the group to the question as to what they would expect from their therapist, who should conduct the group meetings, etc.

STENOGRAPHIC EXCERPTS FROM THE GROUP DISCUSSION

Therapist: "Who should conduct the group?"

Beatrice H.: "You, of course. But if you were not here a social worker could take over but it won't be so interesting as if we had a doctor."

Therapist: "Would any one of you ladies take over and conduct such a meeting if I were absent from the session?"

Adrienne C.: "Oh, no doctor. We could not do that."

Beatrice H.: "Why, Adrienne! Of course you could do it if you tried."

Adrennie C.: "I think that Beatrice did a good job when you were away in order to talk to these visitors the other day, doctor. We were like an army without a leader."

Therapist: "What qualities would you expect to find in your group leader and what qualities would you resent in him or her?"

Beatrice H.: "I like a friendly doctor. I don't want to be afraid of him. Even if he is no doctor I want a nice, gentle person, somebody who could be my friend. Of course, I think we should have a psychiatrist because so many of us are depressed or excited at times."

Anna A.: "I want a nice person. A doctor with a nice personal appearance and good habits."

Adrienne C.: "I don't mean to say that the doctor has to be good looking. It sure helps but it is not absolutely necessary. I knew a doctor who was homely and yet we all liked him. He did not have any bedside manner either. He used to holler at us kids and my mother would become upset and call him a 'son of a b—', but we liked him all right."

Ruth F.: "I knew a doctor who was so nice that you could tell him even hard luck stories. He always lent me a willing ear. But there was another one to whom you could tell only the good things. He would become annoyed when you bothered him with hard luck stories and in the end you decided to keep them to yourself. That is not so good in such a group if we could not tell you, doctor, about our troubles."

Adrienne C.: "I would not like a bossy doctor who tells you what to do and who does not want to answer your questions as some of the attendants do!"

The patients immediately formed transference reactions, not only toward the therapist but also toward members of the group. Topics dealing with feelings toward the patients and relatives were brought up frequently, bringing the patients' likes and dislikes out into the open. The feeling that they were once more members of families dominated by parental figures gave them a chance for reliving and resolving traumatic experiences with subsequent healthy maturing:

Therapist: "How do you feel about me, ladies?"

Beatrice H.: "We all like you, doctor."

Betty C.: You could be our big sister or cousin."

Adrienne C.: "Why not our mother?"

Anna A.: "She is too young to be our mother, aren't you, doctor? I don't want to say anything bad about my mother but . . . no, doctor, you are not like my mother at all."

Betty C.: "What's wrong with your mother, Anna?"

Anna A.: "I don't want to say it. I don't want to talk about it. Do I have to, doctor?"

Therapist: "Of course not, if you don't want to."

Ruth F.: "I have an inferiority complex and it is all my mother's fault. I can't even go to the commissary and do the shopping. I can't bring home the bacon. I'm too clumsy."

Betty C.: "What do you mean, Ruthie?"

Ruth F.: "Oh, they used to say at home that I was not reliable. Maybe I'm not. I think I'm too careful. Some girl here gave me some money, the way my sister always did, and asked me to bring her some ice cream. I meant to be so careful and yet I dropped the package, just like I did at home that day, and everything went wrong that day. Of course, I gave the girl the money back. I had to make good the damage but I never went shopping again after that." (Cries.)

Beatrice H.: "Cheer up, Ruthie. Next time I'll send you to get me something and you won't drop it, you'll see."

Therapist: "Why do you blame your mother for what you call an inferiority complex, Ruth?"

Ruth F.: "She made me put up a front. She wanted me to be smart. I never liked her."

Betty C.: "Because she was bossing you around the way the attendant here bosses me around."

Ruth F.: "Oh, no. Not at all. She was not bossy but she liked my sister so much better. She was the prettier one."

Betty C.: "With me it was about the same. I never got anywhere when I was a child. My father built me up, my mother tore me down. I'm

speaking about my good points. My mother said I had no good points. She condemned me completely. When I wanted to get a job she told me I was not well enough to work. When I went on a date she told me that I would never get a husband because I was too homely."

Anna A.: "My father, Heaven forgive me, always said that I was too fat. He said that I looked like 80 years old. He hurt me terribly with talk like this . . . I should not say bad things about my parents."

Therapist: "Perhaps it is quite good for you to get these feelings off your chest, Anna. You will feel much better next Sunday when your father comes to visit you."

Adrienne C.: "Talk never hurt anybody. I feel much better about everything and everybody if I talk about it. I like you much better now, doctor, than I did when we first started out with the sessions!"

Goals and Advantages of Group Psychotherapy

The smaller the group and the more intelligent and rational the patients, the more intensive becomes group psychotherapy. In a favorable group climate, the patients will feel secure enough to bring up their own personal problems instead of merely touching the more conventional topics on broad general terms.

It happened to this writer that several members of the smaller group spontaneously suggested that they talk about intimate and delicate problems which they had not dared to discuss during their individual psychotherapeutic interviews. Group psychotherapy began to resemble group psychoanalysis. It dawned on the writer that the goals of group psychotherapy are similar to those of individual psychotherapy when given on a deeper level of interpretation and treatment. In addition to these goals, there are other goals which cannot be reached in individual therapy such as the goals of integration and socialization accomplished only within and by the group.

Like every other form of psychotherapy, group psychotherapy awakens and strengthens the constructive forces in the patient. It helps him to overcome his mental isolation; to resolve his conflicts and thus to do away with the formation of pathological symptoms such as delusions and hallucinations, which are nothing else but the auxiliary mechanisms and externalization and projection, in an attempt to do away with unresolved inner conflicts. Once the conflicts are faced and resolved, the symptoms are ameliorated and finally disappear altogether.

Group psychotherapy helps the patient to establish better interpersonal relations and better relations with his own self. Through catharsis and objectivation, the patient learns to crystallize his own and other peoples' problems and so gain real insight into the nature of his conflicts. Since the group is an ideal testing ground for one's own strength or weakness, it helps the patient to reach independence through self-expression and establishment of his own set of values. The group dramatizes the importance of mutual interest, mutual confidence and mutual respect, and creates healthy self-confidence and self-respect.

Group psychotherapy enhances the patient's reality testing, which is necessary for obtaining insight into his own and other patients' problems and symptoms. It enables the patient to tolerate constructive criticism and to criticize others in a rational and tactful manner. For the group rapidly exposes irrational drives and therefore strengthens the patient's reality value. At the onset of psychoneurosis or psychosis, the patient lives in imagination and turns his back on reality. He sees himself in terms of an idealized image and tries to live up to it. The group quickly recognizes him for what he really is and brings him down to earth. He begins to see and to accept himself as a human being with all his genuine assets and shortcomings. He stops making claims on himself and his environment (in this instance, on the therapist and the other members of his group). He gives up not only his false pride, but also his self-contempt; and unjustified self-hatred diminishes rapidly. Many of his delusions and hallucinations are undermined—much more quickly in the group than in individual psychotherapy.

By the time the patient is ready to leave the hospital, he is able to resume responsibility for himself and others, to make his own decisions without shunning the consequences; he has achieved inner independence.

Group Psychotherapy and Individual Psychotherapy

As already noted, group psychotherapy has similar goals to those of individual psychotherapy; but there is a difference in degree of improvement and the length of time until improvement occurs. Group psychotherapy has its own advantages, limitations and dangers. Advantages over individual psychotherapy lie in the number of patients which can be reached by a single therapist; in

the accelerated mode of therapeutic action; in the facilitation of socialization and integration into the group; in the strengthening of reality testing; in the added recreational factor, etc. Limitations are seen in the difficulty of giving continuity to the conduct of the treatment and in the difficulty of devoting enough attention and time to each individual group member; in the "dilution of transference"; and in the difficulty of reaching a given depth in the level of treatment in the group. The danger lies in premature interpretation and criticism by group members before the individual concerned is able to tolerate it, an event which calls forth an increase in anxiety which may amount to panic. This may lead to a relapse of mental illness. A further danger moment lies also in the barring from the further possibility for individual psychotherapy of anxious and disturbed patients.

However, instead of asking the questions as to whether group psychotherapy is preferable to individual psychotherapy, the writer has come to the conclusion that both are necessary and that they supplement each other; that one kind of therapy may reach one type of patient better than another type. This writer gives individual psychtherapeutic interviews prior to the group formation in order to familiarize herself with the individual case histories and character structures; in order to choose suitable members for the future group; and to initiate and promote a good doctor-patient relationship. While group psychotherapy is in progress, several of the group members will continue to receive additional individual treatment in order to alleviate overwhelming anxiety and to provide for additional support and clarification of individual problems that cannot be fully gone into during the group session.

Technical Aspects

With the increasing experience of the therapist, and the decreasing size of the group, the method of conducting the sessions changed automatically. In the larger group, neither the therapist nor the group members felt at ease during the initial sessions, and there was a need for strict authority and skilled leadership by the therapist. Therefore the didactic and organizing method was brought into the foreground. As the strength and integration of the group increased, the position of the leader of the group as well as the kind of technique applied changed rapidly. Foulkes speaks

of an "all important decrescendo move of the authority of the leader." The leader in the writer's groups became more of a conductor and moderator and submitted completely to the needs of the group. The writer lets the group members ramble rather freely about any topic of their choosing; she participates in the discussion if asked to do so, and participates in the patients' recitals of poetry, drawings of little sketches, and singing of folk songs after the regular sessions. Sometimes she leaves her seat in the center of the group to one of the patients who started the discussion, and sits with the group members while watching and listening—always ready to help out, moderate and make quick decisions. Thus, a wealth of new features could be observed in group psychotherapy which were never noticed during individual psychotherapeutic sessions.

The previously used method of holding half-hour lectures was completely abandoned because it now hampered the spontaneity of the group. Instead of making attempts to educate the group by scientific lectures, spontaneous discussions were encouraged even if the topics were not strictly of scientific, but only of general human, value. The patients still put little slips with questions in the empty cigar box placed on the center table at the beginning of each session. They answered all the questions themselves in a very naïve manner but always consulted the therapist for her opinion. Some of the questions are rather transparent and convey the motives of the questioner to the group. For instance, one of the questions read as follows: "How much does a train ticket cost to the city and what is the nearest way to the railroad station?" The patients bring along short articles cut from popular magazines and reviews of books they borrowed from the hospital library or from those offered to them by their therapist. Little sketches, drawn by the members at the end of the sessions, serve as excellent starting points for free associations and interpretations. Many of the participants are capable of writing really good poetry and prose, which is read to the group members and published in the patients' own newspaper, the *Hospital News,* which appears monthly. Since the groups are "open groups" allowing their members to drop out and admitting new members at any time, it has been found necessary to address the newcomers with a little speech made up either by the therapist or by a volunteer from the group. One of the

women, Anita B., a very intelligent manic-depressive patient, typed the following address.

1. We are here in a mental hospital and none of us wanted to come and stay here. You wonder why you have to stay here. One purpose of these meetings is to explain this to you.

2. You are here because you have had a nervous breakdown. You either know that you have had one or you don't realize that you had one. You see that what we call nervous breakdown might really be a wrong way to react to certain things and we may have acquired this type of faulty reaction to life situations when we were children.

3. Having seen why you are here we want to show you how to correct the difficulty so that you may go home. Our reason for meeting in this little group here is to learn to understand ourselves. Most people do not understand themselves. By discussing our problems in a group we have several advantages: (a) We listen to the problems of other people and by comparing these with our own problems we learn to judge them more objectively. We may often be afraid to face our own problems but we are not so touchy about the difficulties another patient has experienced. We often see the solution of the difficulty for the other fellow and all of a sudden we know how to solve our own problem. (b) We might have thought that we are quite unique and that nobody has similar difficulties. We are ashamed to discuss such things even with our relatives or our private doctors. Here we discuss the same things in a group and seeing that the other fellow has similar problems we feel better right away. (c) By discussing our difficulty, in the little group, we learn to understand the other person better; we even come to like him or her and in this way we get a new outlook on people and life in general. We may find it easier to find new friends and all this together makes for much better adjustment.

The following topics were chosen by the participants of the group as the most popular ones for general discussion: 1. About the nature and origin of mental illness. 2. How mental illness started in the individual group member (with voluntarily submitted brief case histories). 3. Dreams and attempts at interpretation. 4. Anxiety and fear. 5. Cancer and venereal diseases. 6. Shock treatment. 7. The language of the body (psychosomatic medicine). 8. Love and sex; failure in marriage. 9. Religion and Faith. 10. Inferiority feelings; how to become more successful in life.

Merely in order to create an adequate frame of reference for discussions on these topics (which were always freely chosen), the therapist thought it necessary from time to time to give a brief outline of an accepted theory dealing with the psychodynamics of neurosis and psychosis. Only very simple everyday language was

used, and the concept of the unconscious and its working as described by Freud was explained. Otherwise, there were no lectures given; only occasional explanations were offered, and free discussions in the group were encouraged.

This writer found it to be helpful and of great comfort to the group to stress certain tenets of Horney's theory on human growth: that human beings are born good and, given the opportunity to develop unrestrictedly in favorable environments, will develop into mentally and morally sound individuals. Destructiveness, crime, and mental disorder are considered to be the result of inhibition of normal growth. Horney points out that a crippled tree is not to be considered a healthy tree but one that has grown in poor soil without sufficient space and sunshine to promote healthy growth and development of its inherent potentialities. This same idea can be applied to human beings. A morally inferior or mentally sick individual is to be viewed from the vantage point of inhibited growth. It is pointed out that the symptoms of neurosis and psychosis arise as a consequence of failure to develop good interpersonal and intrapersonal relationships. Heredity is to be mentioned but not stressed, since it is felt that only the most optimistic attitude should be brought home to the patients.

The books and magazine articles alluded to and partially quoted or read by the therapist and group members during the last year were the following ones:

Freud:	On the Psychopathology of Everyday Life
	The Interpretation of Dreams
Horney:	Neurosis and Human Growth
Rollo May:	The Meaning of Anxiety
	Man's Search for Himself
Fromm:	Man for Himself
	The Forgotten Language
Strecker:	Beyond the Clinical Frontiers
Zilboorg and Henry:	A History of Medical Psychology
Klapman:	Group Psychotherapy
	Social Adjustment

Only a few selected paragraphs and clinical examples were read or quoted from these books—all this within the frame of the group discussions on these particular topics! Magazine articles which were most enjoyed by the patients were the following ones:

Esquire, July 1953: "New York, Crack-up City." By Helen Lawrenson. (This article deals with the dangers of the large cities for development and maintenance of a sound mental life and compares country life to life in New York City.)

Ladies Home Journal: A series of articles entitled "Tell Me, Doctor," which deal exclusively with female problems.

Harpers Magazine: "Palm Springs: Wind, Sand and Stars." By Cleveland Amory. (Depicting the feeling of futility by means of fun-seeking in the leisure class.)

Many other articles, reviews of recent books and reviews of movies shown in the patients' dining room were read and discussed by the participants, a procedure which proved to be stimulating and entertaining.

Many participants in these group psychotherapy classes who were placed on convalescent status, attended group psychotherapy sessions on the out-patient clinics and kept on writing letters to the therapist and the group members in the hospital. Many of them continued to send in self-composed poems and prose for publication in the *Hospital News* for patients. Here is one that reflects the hopeful outlook of a group member who recovered and made an excellent adjustment on the outside; she aptly gave it the title of:

Recovery

The fears and doubts are gone and I am free
To be myself and I can plan my life
In this or that direction, I will strive
To do just what I want. I will agree
to be myself
No more will I submit to will of others
To do what I feel right
Will be my only fight
From now on. Nothing bothers
the one who found himself.

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SPURIOUS HOMOSEXUALITY

BY EDMUND BERGLER, M. D.

According to the statistics of Kinsey's earlier study, the one on the male, one man out of three had had some kind of post-adolescent homosexual experience. In a paper refuting Kinsey's conclusions,* the writer pointed out that this one-third of the adult male population, plus the Lesbians (who have been estimated by Ellis and Hirschfeld at double the number of male homosexuals, although Kinsey's second study underestimates them), would total approximately 50,000,000 people in this country alone. They would thus constitute the core of what can only be called a new national disease, dwarfing tuberculosis, cancer, vascular and heart troubles. In the writer's study, he called Kinsey's conclusions on male homosexuality a myth, pointing out the faults in his deductions (these can be read in the original), and also presenting the writer's objections to his other "finding," in which it is denied that homosexuality is a disease and it is classified mainly as a slight shift in an equally mythological "homosexual-heterosexual balance."

Aside from the controversial nature of Kinsey's approach, the problem of homosexuality has been scientifically neglected of late. Homosexuality still seems to be so uncomfortable a question, and one which is so shamefacedly clouded, that nobody wants (or dares) to talk about it.

There is no point in repeating the statements embodied in numerous studies the writer published on the subject,** reporting the results of genetic investigations conducted over the course of more than 20 years, on more than 100 analyzed patients. These results have been summarized in *Neurotic Counterfeit-Sex*.† In the present paper, the writer wants to concentrate on spurious forms of

*Bergler, E.: The myth of a new national disease—homosexuality and the Kinsey report. PSYCHIAT. QUART., 22:66-88, 1948. Enlarged in: Kinsey's Myth of Female Sexuality (in coll. with W. Kroger), Grune & Stratton. 1954.

**Among these are: The present situation in the genetic investigation of homosexuality, Marriage Hygiene (old series), 4:16-29, 1937; Respective importance of reality and fantasy in genesis of female homosexuality, J. Crim. Psychopathol., 5:27-48, 1942; Lesbianism: facts and fiction, Marriage Hygiene, 1:197-202, 1948; Eight prerequisites for the psychoanalytic treatment of homosexuality, Psychoan. Rev., 31:253-286, 1944. This last-mentioned paper contains a cross-section of the extensive literature on the topic.

†A triple monograph on impotence, frigidity and homosexuality. Grune & Stratton, New York, 1951.

homosexuality. The phenomenon of homosexuality is *not* a unit (in *The Basic Neurosis*,* 11 different forms and subdivisions were enumerated, some of which are spurious and not genuine); to complicate matters, additional spurious forms are constantly being detected.

A genuine homosexual is by no means an "effeminate man," a matter best proved by the fact that the active partner in homosexuality does not fit into the effeminacy picture. A male homosexual is a person who predominantly uses the unconsciously-based defense mechanism of man-man relationship to escape his repressed masochistic attachment to the image of his pre-Oedipal mother, and who shows predominantly in his personality the mechanism of the "injustice collector" based on oral-masochistic regression. The combination of these *two* ingredients is the only basis that constitutes the homosexual.

Analytic investigation of male homosexuals has proved to the writer that homosexuals are, unconsciously, merely fugitives from their infantile misconceptions—misconceptions which (also unconsciously) were built up around their mothers in the nursery. Two specific characteristics identify the homosexual. In his personality structure, he is a typical, orally regressed, masochistic injustice collector; in his sex life, he is a constant seeker of a "reduplication of his own specific defense mechanism." The latter term denotes a *specific* elaboration of the trauma of weaning. Normally, the boy unconsciously identifies penis and breast (bottle), thus inwardly denying that he has been in any way deprived.** The future homosexual does not make this shift; he is so angry with the "denying" sex that he must reassure himself by duplication of his own "nullification trick." He seeks the penis of the partner (meaning—himself).

In the great majority of cases, therefore, since hormonal cases are rare and exceptional, the perversion, male homosexuality, is a purely genetic-psychological problem. The prognosis for analytic treatment, provided the oral basis is reached and proper selection of cases is adhered to,† is excellent.

* * *

*Grune & Stratton, New York, 1949, pp. 213-237.

**See the writer's: The breast complex in the male (in coll. with L. Eidelberg), Int. Zeitschr. für Psychoan., Vienna, 19:547-583, 1933.

†Eight prerequisites for the psychoanalytic treatment of homosexuality," l. c.

In recent years, the writer has observed a series of types of spurious homosexuality in addition to those already described in previous publications. These will be reported on presently.

Summarized briefly, the spurious forms previously clarified are:

1. *Transitory Phase in Adolescence.* Kinsey (*Sexual Behavior in the Human Male*) found statistically that future homosexuals have a precocious adolescence, and concluded:

". . . As a factor in the development of the homosexual, age of onset of adolescence (which probably means the metabolic drive of the individual) may prove to be more significant than the much discussed Oedipal relation of Freudian philosophy." (p. 315.)

There are two objections to this deduction. First, the Oedipus complex is not basic for homosexuals, as studies by E. Jones and H. Deutsch have shown for Lesbians, and the writer's own studies (originally conducted with L. Eidelberg) have suggested for male homosexuals. Moreover, the early onset of maturation is but the *somatic* expression of a *psychologic* fact. Inner conflicts influence glands of internal secretion no less than glands with inner secretions influence inner conflicts. One could assume that early puberty is an antedated defense expressed organically. The activity inherent in the sex drive may be used as defense against the passivity and *guilt* revolving around reverberations of the infantile conflict. In favorable cases, puberty can decide the battle of infantile passivity and guilt in favor of activity. People with greater than ordinary conflicts, such as orally regressed neurotics, try to save themselves earlier with biologic help. Kinsey's statistical revelation of early adolescence in homosexuals, therefore, might be in effect an argument against his assumption of "heterosexual-homosexual balance."

2. *The Passive-Feminine Hysterical Milquetoast,* regressed to the negative Oedipus. He is no more a homosexual than an inhabitant of the moon. Nevertheless, in his secret monologues, he accuses himself of homosexuality; and in less secret logorrheaic gatherings, women accuse him of being one. He is rendered suspect by his frequent potency disturbance,* for the dangerously misleading and silly formula declares: "Impotent, *ergo* a fairy."**

*See: Differential diagnosis between spurious homosexuality and perversion homosexuality, PSYCHIAT. QUART., 21: 399-409, 1947.

**There are literally hundreds of elaborations of genetic reasons for psychic impotence. See: Neurotic Counterfeit, l. c.

3. *Homosexual "One-Timers."* A very large number of men have one or two homosexual experiences but no more. Genetically, this group is extremely heterogeneous; a large variety of unconscious reasons lead to the homosexual interlude. For the most part, these men are not homosexuals.

4. *Temporary Oral Regression in Specific Situation of Stress.* The transitory homosexual episodes of men inducted into the armed services during a war belong in this category. Loneliness, danger, fear, provoke the unconscious infantile accusation: "Bad mother is responsible." The masochistic attachment thus revived is warded off with pseudo-aggression which leads to the "revenge" and reassurance of the homosexual act. The whole process is of course unconscious.

5. *Allurement of the Forbidden.* In some cases the homosexual episode is no more than an expression of the masochistic wish for a brief foray into "forbidden" territory. In the same way, not all the persons who drank during prohibition were drinkers; some were looking for the "adventure of danger" (psychic masochism).

6. *Shifted Guilt.* Frequently guilt pertaining to other inner causes is expressed in isolated homosexual episodes. This guilt may have its origin in entirely different sources.

7. *The Mirage of Lack of Heterosexual Objects.* One of the pillars of the assumption that there is a shifting and exchangeable "balance" between heterosexuality and homosexuality is the argument that in prisons even men who have previously been heterosexual become "homosexuals." A curious oversight is involved here. Most prison inmates are persons who use the "mechanism of criminosis"—hence an orally determined solution occurs. The problem cannot be discussed without elaboration of the problems of the genetic factors leading to crime in general.*

8. *Homosexuality as Inner Admission of the "Lesser Crime."* There are literally dozens of elaborations of the "mechanism of orality" leading to injustice-collection. As stressed in the writer's many previous papers and books, the presence of that mechanism is proof of oral regression. (A specific additional mechanism explains why the resulting clinical pictures differ.) There exists, however, one type of orally-regressed man who uses a strange defense in his "battle of the conscience." Accused by his super-ego

*See *The Battle of the Conscience*, Washington Inst. of Medicine, 1948.

of masochistic repetition of an infantile conflict with the mother, projected upon a woman (he consistently associates with termagants), he intrapsychically denies the attachment by *temporarily* running to the *man*. These neurotics use transitory homosexual "spells" as defenses against another "crime": that of masochistic attachment. They *fortify themselves*, so to speak, with *doses of homosexuality*. They gain "immunity" from women by using the homosexual conflict. Inevitably, they revert to termagants again after a short time, and the identical procedure is repeated. The whole process is of course unconscious. It is very likely that this type accounts for Kinsey's observation of *sporadic* homosexuality in specific ages in specific individuals.

* * *

The newly-observed types of spurious homosexuality follow.

9. *Magic Gestures Camouflaged as Unconscious Homosexuality.* A patient, a well-known journalist, frequently developed "suspicious enthusiasms" for the prominent people on whose biographical sketches he was working. Understandably enough, these "great men" were on their best behavior with their biographer; they exhibited neither rudeness nor superciliousness, and often skillfully play-acted, in their interviews, the role in which they wish to appear before the public. The writer's patient—naïvely enough—was more than flattered. His first draft descriptions of these people were encomiums rather than appraisals, advertising rather than journalistic copy.

Contrary to his own assumptions—which were shared by those editors who did not cynically conclude that his good opinions had been bought and paid for—the unconscious reasons for these short-lived attachments had no connection at all with unconscious homosexuality. These attachments were the result of a "magic gesture." The term* denotes unconscious dramatization of how one allegedly wanted to be treated as a child—kindly and lovingly. Careful scrutiny of people who habitually perform magic gestures reveals them as severe psychic masochists who use the gesture as a weapon in fighting their "battle of the conscience." To counteract the super-ego reproach directed against the passive-masochistic solution of the infantile conflict (the initial inner defense), pseudo-aggression is mobilized. When this, too, is vetoed by the

*See: The problem of magic gestures, PSYCHIAT. QUART., 19:259-310, 1945.

inner conscience, a second inner defense—the magic gesture—is put in operation. Both the masochistic attachment to the enshrined parental images, and the pseudo-aggression against them, are thus negated: "I just want to show how I really want to be treated, with love and kindness."

Confronted with his series of "great" men, the journalist responded with a series of magic gestures. In this defense, he denied his masochistic attachment to the mother of infancy, even adding an *argumentum ad hominem*: "If mother had been loving to me, I would have been loving to her—as I am toward this stranger."

In a series of cases, the writer has observed that people who perform magic gestures are apt to be accused of homosexuality (or Lesbianism). Homosexuality appears to be an adequate explanation, because the behavior of the person who makes the magic gesture is in contradiction to his usual behavior. If, for example, a miser starts to shower gifts, introductions, parties on an unimportant outsider who happens to be of his own sex, the misjudgment is understandable, provided one has no knowledge of the existence of the phenomenon, the magic gesture. It is also interesting that the masochistic "crime" is so severely judged intrapsychically that even the suspicion of homosexuality is taken to be the "lesser crime."*

10. *Masochistic Attachment Giving the Appearance of Unconscious Homosexuality.* Another source of misconceptions, and another starting-point for unwarranted accusations of homosexuality, is the often-encountered situation in which one man uses another as a hitching post for rejection—of course unconsciously. The observer mistakes an unsolved masochistic attachment, dating from infancy, projected by the adult upon an innocent bystander, for a homosexual attachment. Repeatedly, patients have told the writer of male friends who were homosexually attached to them. In many of these cases, those very friends have subsequently come into analysis; and—after excluding the possibility of projection—it could be ascertained that nothing of the kind was involved. The friend was merely getting his "daily dose of injustice" by associating himself with a person who was (superficially) cold, emotionally inhibited, and seemingly detached.

Once more, since the outer world does not know anything about psychic masochism, attachments which have their *raison d'être* in

*For the ubiquity of this defense, see: *The Basic Neurosis*, Chapter 3 (l. c.).

the need for injustice collecting are credited to homosexuality when the relationship is between two persons of the same sex.

As a literary example, the case of Herman Melville can be adduced. The author of *Moby Dick* has been repeatedly accused of such an attachment to Hawthorne. The myth is quite alive, as the following quotation from a very serious magazine (*The Freeman*, August 13, 1951) proves:

"Melville's *Moby Dick* is satanism washed in the innocent blood of the lamb. Ahab is not wicked; he is fissured, lonely, like the whole Pequod ever crying out for the marriage-pillows that were never to be theirs. The only hymeneal in *Moby Dick* is the wedlock friendship between Queequeg and Ishmael, and though this reminds us of the love Hamlet has for Horatio, Queequeg is such a virgin cannibal that he has to crawl under the bed to put on his shoes because Ishmael is present. *Billy Budd,* Melville's last work, *is epicene as the name suggests.* Indeed, an almost exclusive male friendship was dominant in nineteenth-century America: *it was not Melville's Plymouth Rock marriage to Elizabeth Shaw but his affection for Hawthorne that mattered. . . .*"

("Our Avant Garde Illiterates," by Edward Dahlberg; the italics are the present writer's.)

Moby Dick (1851) and Billy Budd (1890) are nearly 40 years apart, and reflect the *change in methods* with which Melville fought his own psychic masochism. In Moby Dick, he projects all the cruelty attributed to the pre-Oedipal mother onto the *devouring* white whale whom he *fights* in identification with Ahab. In Billy Budd, there is complete *submission* to psychic masochism: At the foot of the gallows the innocent but condemned youth exclaims, "God Bless Captain Vere" (the man who is sending him to his death).

In any case, it is entirely misleading to accept literary production as verbatim testimony. Unconsciously, the writer expresses only *secondary* inner defenses. This topic has been dealt with at length in the present writer's book, *The Writer and Psychoanalysis.**

Melville's relation to Hawthorne was based on the identical masochistic precepts described. Hawthorne was assigned the role of the rejecting party, and—with his "deep silences" and charac-

*Doubleday, New York, 1950.

teristic withdrawals—needed no coaching to play it excellently. Hawthorne was either unwilling or unable to reciprocate Melville's feelings; one might suspect from *Ethan Brand* that his inner attitude toward Melville was a rather ironic one. Melville's choice of Hawthorne as a friend was clearly masochistic:

"Hawthorne was essentially as remote from Melville as he was from the old worthies of the Customs House at Salem or the old sea-captains he had exchanged civilities with over a mug of ale."

(Lewis Mumford, *Herman Melville*,
The Literary Guild of America, 1929.)

The Hawthorne episode is only one of a long series of self-provoked masochistic actions in Melville's life. Here are a few other examples:

As a young man, Melville spent four months as the captive of a cannibalistic South Sea tribe, the Typees (the tribe later described in detail in his book, *Typee*). Although he knew that he was in constant danger of being devoured, Melville provoked the chief by asking him to break one of the tribe's most sacred taboos—that of forbidding any woman to use or even touch a canoe. Melville made the request because he wanted to take a canoe-ride with a Polynesian girl, Fayaway. In his own words:

"Although the 'taboo' was a ticklish thing to meddle with, I determined to test its capabilities of resisting an attack . . . It was high time the islanders should be taught a little gallantry . . . Ridiculous, indeed, that the lovely creatures should be obliged to paddle about in the water, like so many ducks, while a parcel of great strapping fellows skimmed over its surface in their canoes."

(*Typee*, p. 140.)

Melville's dangerous captivity among the Typees had been self-provoked, to begin with. Without either weapons or provisions, he had run away from a whaler; and of two alternative refuges, Typee or Happar, had fallen into the hands of the Typees, who were known cannibals, and not into those of the Happar tribe, which was reputed to be anti-cannibalistic. (A 50-50 chance!) The unconscious allure of the question, "Typee or Happar?" remained externally and internally paradigmatic for Melville—see *Moby Dick*.

Here is another instance. After the failure of *Moby Dick*, Melville wrote *Pierre* (1853), a clear-cut incestuous story. Did he ex-

pect to "make a living" as a writer by using incest as his theme, in the officially Puritanical American society of 1853?* This rather rhetorical question is supplemented by an actual experience Melville had with his first book, *Typee*. He was persuaded to bowdlerize it in a "revised edition." What was eliminated? Such harmless anecdotes as that of a "South Sea queen, Pomaree, examining the tattooing of a French sailor, and, in all innocence, raising her skirt so as to disclose her own to such a connoisseur of the art; or the incident of the beautiful yellow-haired wife of a missionary, who was worshipped by the natives as a mysterious goddess until they stripped her of her clothes and discovered that she was even as they . . ." (Mumford, l. c., p. 75). If even allusions to sex in remote parts of the world were taboo to the American society of Melville's day, how much response could he have expected for a book on dramatized incest, like *Pierre*?

11. *Community of "Pseudo-Superiority," Misjudged as Unconscious Homosexuality.* In every group or organization, the following spectacle is observable: An "old-timer" introduces a "neophyte" into the "mysteries." Temporarily, the two become deeply attached to one another, and observers conclude that "something is going on," as the phrase runs. Something *is* going on, but it is not homosexuality. Both—the neophyte directly, the old-timer via identification—are enjoying the infantilism of peeping at the forbidden!

A letter from a witty woman, Mrs. M., describes such an alliance. Mrs. M. has a husband urgently in need of analysis. Their best friends are Mr. and Mrs. N.; Mr. N. is in analysis with the writer. Mr. M. had come for consultation once, and it had been agreed that his analysis would start after the writer's vacation. During this interview, Mr. M. had looked so longingly at the writer's cigar that the writer had offered him one. Here is an excerpt from Mrs. M.'s letter:

". . . My second story has to be developed to be told right. It has to do with that new team of lovebirds, my husband and Mr. N. This affair began the day my husband returned from your office—cigar and all—looking cured as hell. N. was so elated you'd have

*The unconscious reasons prompting Melville to write the succession *Moby Dick—Pierre* are discussed in *The Superego*, Chapter V, Grune & Stratton, New York, 1952.

thought 'bergler' was a new form of chemical,* *known only to him,* and now to my husband. Mrs. N. and I were sure the boys were about to set up housekeeping together. The cigar, I must add, was partly smoked by N. and lived long enough to show up at a poker game ten days later—dragged out by N. for luck—on account of his losing his shirt. . . ."

12. *Pseudo-Homosexuality of a Specific Type of Voyeuristic Masochist.* The writer has repeatedly observed neurotic men who either suggest that their wives start affairs with other men, or even force their wives into such affairs. The men in mind are not pimps; they derive a specific pleasure from these indirect or direct voyeuristic practices. Some of these patients had been in analysis before consulting the writer; in these prior analyses their actions had been interpreted according to Freud's formula for specific types of jealousy: unconscious feminine identification. Typically, this identification was confused with unconscious homosexuality, and these patients frequently presented themselves with this diagnosis.

This diagnosis, however, proved incorrect. The feminine identification—typically enough, this was sometimes half-conscious—was only a blind, and a means of "taking the blame for the lesser crime." The *real* "crime" was the more deeply repressed masochistic regression. This could be proved by the fact that many of these neurotics constantly felt: "unjustly treated" and "cheated" by their wives, and complained to friends of their wives' alleged infidelity.**

* * *

These 12 types of pseudo-homosexuality (by no means complete) indicate the extent of the care which must be taken in pronouncing the dictum, "X. is a fairy." A great deal of damage is done by the wrong diagnosis. There are enough homosexuals around; there is no need to augment their number by lumping pseudo-homosexuals with them.

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*Both M. and N. are chemical engineers of standing, with many original achievements to their credit.

**This expedient of complaining to friends had the advantage of settling the scopophiliac conflict; voyeurism was warded off with exhibitionism.

SOME PROGNOSTIC CRITERIA FOR RECOVERY FROM PSYCHOSIS FOLLOWING PSYCHOSURGERY

BY CARNEY LANDIS, Ph.D., D. Sc., AND VIOLET HAMWI, M. A.

The prediction of whether psychosurgery will alleviate psychosis, particularly schizophrenia, remains uncertain in spite of the fact that more than 10,000 psychosurgical operations have been performed in the United States alone during the past 15 years. From a survey of 205 bilateral prefrontal lobotomy cases, Arnot, Talbot and Greenblatt[1] expressed the view that, "The patient most likely to improve with lobotomy has achieved a measure of maturity before illness . . . has shown at some time a tendency to attacks with improvement . . . has an anatomically intact brain . . . has had a good prepsychotic adjustment . . . has evidence of considerable external stress . . . develops the psychosis acutely . . . the duration of illness and hospitalization is relatively short . . . and except for refusal of food, depression or elation, or obsessive compulsive phenomena, his personality and behavior during illness are in many respects normal (satisfactory general appearance, no hallucinations, no delusions, no ideas of reference, and insight present)."

Partridge[2] followed 300 cases over one and one-half to three years after surgery and concluded: "The decision of whether or not to operate must depend on observation with a view to determining whether illness is developing . . . in a fixed and constant form; the more that the content and behavior tend to assume an established abnormality of constant pattern, and the less there are variations and fluctuations in that form, the worse is the prognosis for treatment by operation—or by any other means. . . . The more that the illness involved reaction to the symptoms in the form of perplexity and conflict, the more optimistic . . . the outcome . . . In our schizophrenic patients the further the illness was removed from essential and established schizophrenia, the more that it was affectively colored and the more that it was marked by active psychodynamics contributory to the development and prolongation, the better were the results."

Garrison,[3] using a modified questionnaire technique in the first Columbia-Greystone project, found that topectomy involving the cortex of the frontal poles resulted in a decrease in anxiety and in

complaints, which was associated with improvement from mental illness. "This change is one of affective stabilization which results in a loss of psychomotor tension and of painful preoccupation and self-centered concern with present and past personal problems." Garrison and Olin[4] utilized a directed interview in the second Columbia-Greystone project in order to cover a greater range of topics, with more precise description of the changes in affective attitude which might follow psychosurgery, than could be obtained with a questionnaire. Unfortunately for their purposes, amelioration from psychosis took place in only a very few patients while these investigators were still connected with the project so that their results with respect to affective attitudes were inconclusive. Retaining the same objective but with modified interview methods Garrison and Olin continued their study in the New York State brain research project.[5] For reasons beyond their control, the material which they obtained was never completely analyzed or reported.

It seemed worth while to the present writers to make use of the material which Garrison and Olin had obtained in both the second Columbia-Greystone and the New York State projects, particularly in light of the patients' conditions two or more years after surgery. In going over these records, the writers found material on six patients who subsequent to psychosurgery (topectomy in five of the six) showed marked improvement, so that they were able to leave the hospital and, according to the social service investigation, have maintained their improved status in the community, never having had to have recourse to psychiatric care since leaving the hospital. Material was also available on five additional patients who improved to such an extent that they left the hospital for two weeks or more but then relapsed and returned to the hospital where they have remained.

For control purposes each one of these 11 individuals was matched as closely as possible with another patient who had had psychosurgery but who failed to show subsequent amelioration from mental illness. The matching was done in terms of age and IQ. All 22 patients had diagnoses of one or another variety of schizophrenia. The occlusive indices[6] and psychiatric improvement rating[7] did not enter in the matching. In making these matches only an approximation of true similarity could be

achieved. *The matches were made without reference to any of the material obtained in the interviews.* Table 1 gives the relevant data on these 22 patients.

Table 1. Background Factors for Comparison Groups. In the "Operation" Column, O=Orbital Topectomy; S=Superior Topectomy; VL=Venous Ligation; TO=Transorbital Lobotomy

Patient No.	Age	Sex	Pre-operative IQ	Occlusive Index	Improvement Rating	Operation
			Improved—Out of Hospital			
EI—2	34	M	110	7.0	3	O
EI—3	32	F	96	11.0	3	O
EI—8	37	M	102	2.3	2	S
EI—9	22	M	96	7.0	3	S
EII—5	42	F	119	12.0	2	S
BI—10A	53	F	114	10.5	4	VL
Mean ...	37		106	7.7		
			Unimproved—In Hospital			
EI—1	35	M	112	21.0	5	S
BI—2	33	F	102	16.0	5	VL
DI—7	38	M	91	24.0	5	S
BI—12	26	F	93	34.0	5	VL
DI—1	36	F	111	33.5	5	S
CI—4A	49	M	106	42.5	5	O
Mean	36		102	27.9		
			Improved 2 Weeks or More—Relapsed			
CI—5A	49	M	90	96.0	3	S
DI—2C	35	M	75	32.8	4	S
DI—28	33	F	75	71.7	5	S
BI—7	36	F	85	6.3	5	VL
BI—18	29	F	80	14.0	5	TO
Mean ...	36		81	30.6		
			Unimproved—In Hospital			
CI—16	58	F	97	95.0	5	S
BI—22A	33	F	76	34.7	5	TO
DI—24	37	F	73	76.0	4	O
BI—21	33	F	76	8.3	5	TO
BI—23	29	F	82	78.0	5	TO
Mean ...	38		81	42.0		

In going through the interview material, many sorts of tabulation were made, both as to material supplied by the patients and evaluations on the part of the interviewers. In Table 2, a selection is presented of those items where a fairly clear differentiation could be made between the improved and unimproved groups. From this tabulation the following generalizations may be drawn:

1. Schizophrenic patients who complained of nightmares, of contemplating suicide, of inferiority feelings, obsessional fears, compulsions, breathing difficulties, and tense muscles before operation tended to make marked improvement following psychosurgery. Conversely, patients not having these complaints usually failed to improve following psychosurgery.

Table 2. Complaints and Symptoms Reported by Patients Before Psychosurgery Tabulated in light of the Patients' Status Two Years or More After Treatment

	Patients with sustained improvement	Patients unimproved	Patients who experienced temporary improvement	Patients unimproved
Nightmares	5	0	0	0
Contemplated suicide	4	0	0	1
Inferiority feelings	4	0	0	0
Obsessional fears	6	1	1	0
Compulsions	5	1	0	0
Breathing difficulties	4	1	1	0
Tense muscles	3	1	0	0
Hallucinations	1	6	4	5
Paranoid delusions	1	5	4	4
Confused rambling	1	6	4	4

2. Schizophrenic patients who showed confused rambling in their conversations, and had paranoid delusions and hallucinations usually failed to improve, or at the best had but short remissions following psychosurgery.

3. So far as this limited group comparison is concerned, the predominance of those symptoms usually associated with chronic schizophrenia (rambling, delusions, hallucinations) constitute contraindications for psychosurgery.

4. With these small groups the occlusive index (Table 1) was a pre-operative criterion of improvement.

In general this material is in line with that of Arnot, Talbot and Greenblatt, and with that of Partridge. One way of viewing the situation is to say that the more the symptoms resemble those of pseudoneurotic schizophrenia,[8] the better is the chance that psychosurgery will bring about an improvement; or, on the contrary, the more the symptoms resemble the classical hallucinated, delusional, confused, deteriorated variety of schizophrenia, the poorer are the chances for recovery following psychosurgery. In still another sense, this analysis indicates that, in spite of the fact that

psychosurgery is a "treatment of last resort" the sooner this last resort is called upon, the better the prognosis of recovery in schizophrenic patients.

In a previous publication (Landis[9]), it was pointed out that psychosurgery is done for the "relief of psychic pain." The point was made that there was a unique and peculiar subjective quality to the psychic pain which could be called "anguish," and that the over-all evidence indicated that psychosurgery was effective in patients experiencing such "anguish." If the patient did not have the anguish, psychosurgery could not be expected to be effective. It had been hoped that this survey of the interview material would bring evidence either for or against the "anguish" theory; but the relevant evidence could not be obtained from this data, mainly because the interviews had not been directed toward this particular point.

Summary

Material obtained from interviews with schizophrenic patients before psychosurgery has been studied to see what symptoms, complaints and attitudes characterized those patients who "recovered" following psychosurgery, in contrast to the symptoms, complaints and attitudes of those who failed to "recover" from schizophrenic psychoses. Six patients who were improved, who left the hospital and who have maintained their improvement for at least two years, were compared to six who failed to improve. Another five patients who made a temporary improvement which enabled them to leave the hospital for two weeks or more and then relapsed and returned to the hospital, where they have remained, were compared to an additional five patients who never improved.

Patients of the pseudoneurotic schizophrenic variety, who before operation, complained of nightmares, contemplation of suicide, inferiority feelings, obsessional fears, compulsions, breathing difficulties and tense muscles, tended to be benefited by the operation to such an extent that they have returned to the community and remained there two years or more. Patients whose interviews were marked by confused rambling, paranoid delusions, and hallucinations may either show brief remissions or may be unchanged by psychosurgery.

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IMPROVEMENT OF CHRONIC SCHIZOPHRENIC PATIENTS WITH GUIDED PROBLEM-SOLVING, MOTIVATED BY HUNGER*

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In 1950 the following hypothesis was presented by one of the authors:

"The schzophrenic process is a replacement of adaptive behavior by frozen, stereotyped 'frustration behavior.' Such a process sets in when an individual's threshold of frustration tolerance is passed. When the resulting maladaptive stereotyped behavior results in more frustration, the process is typically progressive."[1]

It was further stated:

"The central hypothesis of this paper suggests a further possible method of treatment which seems worthy of investigation. This is the beginning reestablishment of flexible adaptive motivation behavior by a process of retraining which might utilize simple technics developed in learning studies with animals. Such technics have the advantage of simplicity and clarity. They are easily graded to the capacity of the subject, so that frustration experiences can easily be minimized. If, for example, the patient is given doses of insulin sufficient to stimulate hunger, but insufficient to produce severe symptoms, and is then guided into the winning of extra food by problem solving, beginning with very simple problems but undertaking gradually those of increasing complexity so that the patient is kept both striving and succeeding, it would seem that the patient might be aided increasingly to marshal his frozen resources in adaptive behavior. It would be necessary to make a transition from tangible food reward to intangible social reward, but this might be a gradual transition with extensive overlapping."

This central hypothesis is supported by a variety of evidence, and particularly by the experimental work of Maier[2] with rats. This work demonstrated that stereotyped unadaptive behavior results from continued frustration, and that the process is reversible. Maier was able to reverse it by a few instances of "guidance" of the rat to the correct solution.

The present study is an effort to apply, and to evaluate the effectiveness of, such "guidance" to patients with chronic schizo-

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phrenic psychoses who have not shown a favorable response to other methods of treatment.

Procedure

Selection of Patients

All patients used in this study were taken from one closed-ward building. The majority of the patients in this building were chronic schizophrenics who had had electric shock therapy; many of them had had deep insulin as well. Although occasionally some would become mildly disturbed, and have to be transferred, most were quiet, apparently arrested at the level of automatic ward adjustment. Twelve patients at a time were used in this investigation. To exclude subjective bias from the selection of patients, and effect separation into test and control groups, the following steps were carried out.

The head nurse of the building selected the patients with the following criteria in mind: (1) The patient was a World War II veteran; (2) he had been hospitalized a minimum of one year, a maximum of four; (3) his diagnosis was definitely that of schizophrenia; (4) at the time selected, and for an extended time previously, the patient had not been working in occupational therapy, and was failing to take part in any of the reality-directed programs of treatment.

After a selection of 12 had been agreed upon, the head nurse filled out a Gardner Behavior Chart[3] for every patient. This chart is really a collection of 15 trait-rating scales, each trait concerning some aspect of the patient's adjustment on the ward. For each trait there are five graded statements in concrete, easily understood terminology. This series of rating scales was especially designed for use by ward personnel, and gives a fairly clear picture of the actual adjustment of the patient on a ward.

The 12 G. B. C. scores were next used to sort the patients into three groups. First the patients were ranked in order of size of score (and assumed ward adjustment). Next they were divided into four sets by putting the highest three scores in one, the next highest three in another, and so on. The three patients in each of these sets were finally sorted into three different final groups, using a table of random numbers. The outcome of this process was that each of the four patients in a final group had a match in each of the other two groups whose ward adjustment was roughly equal

to his own. It is also worth noting that the patients of each of the three final groups were of as wide a range as possible in ward adjustment, within this rather homogeneous group of poorly-adjusted patients.

The three groups were a test group (I), which received the special learning treatment, a partial control group (II), which was treated in all respects in the same manner as Group I except for the absence of the learning treatment, and a pure control group (III), whose members received the routine treatment given all patients on their ward.

The eight patients of Groups I and II were separated from the other ward patients at 7:00 every morning. While the other patients were at breakfast, these remained on the ward where they received subshock injections of insulin. Then, with the nurse and two aides, they walked to the O. T. building, one of the aides pushing a food cart containing sandwiches, coffee, fruit juice, milk, and fudge. The rest of the patients from their building arrived at O. T. about 10 minutes later. All patients from this building, including the 12 research subjects, remained in O. T. every weekday morning from 8 to 10.

The patients of Groups I and II, who had received insulin and been denied breakfast, were seated at a single table in one of the two large, connecting O. T. rooms. Every weekday morning, they received an especially intense form of O. T. One or two nurses, two aides, and two student nurses worked every day with these eight patients, and, from time to time, an occupational therapist would be present also. Thus every one of these patients received more than the usual attention given in O. T. and had opportunity to show interest in a wide variety of constructive work, including mat making, ceramics, finger painting, leather work, and small metal work.

At some time during this two-hour O. T. period, these patients were taken in pairs, one of Group I and the other of Group II, to another room where they had breakfast. The order in which they were given breakfast was rotated from day to day; thus no patient ate consistently early or late. Upon arrival in the breakfast room, the Group II patients were immediately seated and given food; when finished they were returned to O. T. The Group I patients were conducted first into an experimental room, adjoining the

breakfast room, where they spent from 20 to 30 minutes at problem-solving with fudge as a reward. This problem-solving was done individually, with only one patient and a psychologist present in the room at any one time. After a patient had completed his learning, he had breakfast and returned to O. T. The patients of Group III were not treated in any way differently from the other patients in the building. With the exception of the psychologist, the head nurse, and the ward physician, none of the personnel was aware of who they were. The routine described for Groups I and II was continued for three months. This period will be referred to herein as the "experimental period."

One of the novel features of this investigation is the use of subshock injections of insulin to motivate, on a biological level, the learning of human beings. The patients of Group I were rewarded for their problem-solving by fudge, which relieves the distressful hunger caused by insulin. There is little doubt that with the type of subjects used in this study there would have been no genuine problem-solving activity without an artificially-induced motivation. Even with it, most of the patients so far used in Group I required intense urging at the beginning and several demonstrations of the fact that the fudge would alleviate their condition. In general behavior, the patients of Groups I and II clearly showed that they were intensely hungry. They often complained of it in words, and they ate with urgency when finally given food. Group I patients would often try to snatch fudge from the table when they passed through the breakfast room, and promptly ate all they could get during the problem-solving. The ward physician increased the amount of insulin for every patient until he was judged to be well into Stage 1. In this condition, the patient shows obvious signs of autonomic reaction, but he does not show marked mental changes, such as confusion and disorientation.

Since the purpose of the insulin was to motivate the patients, and since after several weeks it seemed that they were habituated to the learning, it was stopped in the middle of the experimental period for all eight patients. This seemed to have little effect on the problem-solving behavior. However, the degree of hunger of many of the patients seemed less. A few would not swallow the fudge they won promptly, but would save it in a napkin for later use.

Problem-Solving

Solution and learning of problems, which was done by the patients in Group I on every workday morning for three months, was the critical variable which the investigation was designed to evaluate as a method of treatment. This was started in a fairly gradual manner. On the last two days of the preliminary period of adjustment to insulin, the psychologist sat with each patient in the experimental room for about 20 minutes. This was partly to get some rapport with the patient, partly to get him used to eating fudge there. The patient was allowed to eat all of the fudge he would reach out and take from the box.

The problem-solving proper began with presentation of a simple obstruction problem. The patient could see the incentive but in order to get it had to overcome an obstruction. This consisted of a rectangular tunnel, 18 inches long, with sides two and one-half inches high and two inches wide. It was made of transparent plastic cemented to another large flat piece. When the patient entered the room the tunnel was covered by a piece of cardboard. After he was seated at the table, the cover was removed and the fudge at the center of the tunnel was pointed out to him and he was urged to get it. His attention at first was not called to the three sticks, each six inches long, which lay at one end of the tunnel. The patient was allowed to solve the problem the first time in any manner that he wished. There were usually two typical reactions. One was quick to give up and sit immobile. The other was to stab around at the tunnel with fingers, trying to reach the fudge from the ends, or trying to pull the tunnel from its base, and finally tilting the tunnel and base at an angle until the fudge slid out. The first type of patient was urged, coaxed, and finally, if necessary, shown how to fit the sticks together to push the fudge out. The patient who used the second type of approach was told on subsequent trials not to lift the tunnel from the table, and the psychologist put his fingers on the edge of the base to enforce this ruling. On subsequent trials the patients either solved the problems on their own or did so after demonstration. Between trials, while the tunnel was being reloaded with fudge, the apparatus was covered by the cardboard shield. All patients were continued at this problem until they had developed and perfected a method of solving it. This usually took from two to four days.

The second type of problem was a modification of the stylus maze,[4] made of concentric square pathways with the fudge reward in the center. The fudge was in a small tray which could be pushed along the pathways of the maze with a stylus held by the patient. This maze was made of clear plastic; the five walls, two and one-half inches high, were fitted into grooves on a large base in such a way that the pathways between the walls were two inches in width. Each wall of the maze had a strip of plastic cemented to the top lengthwise, extending out over the pathway. These horizontal pieces left a narrow groove over the middle of each pathway through which the patient could insert his stylus and push the fudge tray. The walls of this maze were movable. The patient was started off with the simplest of all problems, only one pathway and the start compartment (two walls). Next he was given two pathways, and so on until all four were used. With each successive gradation in difficulty the patient was started without any blocks in the pathway. After he had satisfactorily perfected a solution on an open alley form of a problem, blocks would be inserted in the pathways, usually across the path which the patient was in the habit of taking. These blocks made only one path out of the maze possible, leaving all others with blind alleys in them. The patient was able to see the whole maze, except between trials when the fudge and tray were being replaced in the center. For the maze problems, a criterion similar to that used on all others was held to. A patient was considered to have mastered a problem when he did five errorless performances in succession. For some patients, this maze was extremely simple, others had a great deal of difficulty with it. Accordingly, the number of days spent on this type of problem was variable. Some patients had solved all the problems satisfactorily in two weeks, others were still doing maze problems at the end of four weeks.

The third type of problem material introduced, usually during the solving of the stylus maze, was circular pencil mazes. These were similar to the well-known Porteus Mazes,[5] which the subject threads by drawing a pencil line from a start to a finish point. Twenty-two of these were constructed especially for this study. All were circular, with a start point in the center. The patient's problem was to draw the line out of the maze without having to retrace. A successful solution was rewarded with fudge. These mazes were graded in difficulty, in terms of the number of circles

used, number of traps involved, and number of ingoing doors necessary. Patients were given six trials a day on these mazes. If they did not make an errorless performance, they were required to repeat the maze on the following day. It should be remarked that these circular mazes never constituted all of the problem material the patient did on any one day. They were usually introduced after the patient had completed his problem with the stylus maze or with one of the problems later introduced.

A fourth type of problem material was multiple choice learning.[6] For these problems, a special multiple choice box was constructed. The essential point about this apparatus was that in the patient's visual field were 10 levers each of which could be pulled toward him for a distance of three inches. Behind the levers, between the fifth and sixth, was a small tray which could be seen through a transparent plastic screen. This apparatus was always prepared, and baited with fudge, with the patient's view blocked by an opaque screen. When the screen was removed, one, and only one, of the levers would cause the tray to move from behind the plastic screen, so that the patient could pick up the piece of fudge. This type of problem material allows an almost unlimited amount of variation in particular problems. These patients were always started with the simplest of all, one particular lever, say number 3, would always get the reward. After the patient had made five errorless trials in succession, pulling only this one correct lever, he was taken on to the next level of difficulty, which was a simple alternation problem, with all 10 levers exposed. For example, the patient would have to learn to pull alternately levers 2 and 7.

Next he would learn to pull three levers in rotation. After the criterion was satisfied for the rotation problem, the patient would be introduced to problems in which only a limited number of the levers were exposed. This limiting of the levers was accomplished by two sliding panels which could fit into the apparatus, covering certain levels. The first problem of this type was the pulling alternately of right and left levers when only two are exposed. From trial to trial, different pairs of levers, always two adjacent ones, were exposed. A second problem of this type was one in which the patient had to learn the principle of always pulling the middle one of an odd number of levers. If the patient succeeded with these problems, he was taken on to increasingly difficult ones. Probably the most difficult multiple choice problem reached by one of the

present patients was one in which he had to learn the principle: Pull the third from the right lever when the exposed levers are at the right end of the panel; pull the right end lever when the exposed levers are at the left end of the panel.

When it seemed appropriate to a patient's condition, he was introduced to various types of reasoning problems. The most consistently used has been the Binet Ingenuity Problems. Wells' manual[7] has a large number of these, roughly graded in difficulty. Another example of reasoning problems was proverbs,[8] with the patient giving an interpretation of the meaning of a proverb.

The last type of problem material was intended to be a social or interpersonal relation type of problem. The four patients of Group I met in a group on two afternoons a week for the last three weeks of the experimental period. Present in the group, in addition to the four patients, were one or two psychologists, a nurse, two aides, two or three volunteer workers, and occasionally other visitors.

The patients' problems at these group meetings consisted of simple psychodramas. For example, the simplest was probably the drama in which the patient was told to go into a store and buy anything he wanted. In this drama a volunteer worker would be the clerk, and any table would serve as a counter. More difficult problems were interviewing the ward physician with respect to privileges, and meeting a friend on the street after discharge from the hospital.

In presenting the problems described to the patient, it was intended to have him move along several dimensions. He moved from simple problems first to increasingly complex ones; from motor problems to ideational ones. There was a shift from primarily individual types of problems to social ones at the end. It is also considered significant that the patient was required to shift from problems in which the incentive was obtained directly to ones in which he was rewarded indirectly. The fudge tunnel, the stylus maze, and the multiple choice problems were ones in which the incentive was obtained directly, that is, the movements of the patient automatically produced the reward. With the circular mazes and reasoning problems, and, of course, the psychodramas, the reward was indirect. With the first two, the psychologist reached into the box of fudge and handed the patient a piece at the completion of each problem. With the psychodramas no reward other than a so-

cial one was used. During the group meetings, the leader took pains to praise a patient for the least of efforts and as usual the other patients were never adversely critical in their comments.

None of the patients so far used has completed all of these problems without some help. This help, or guidance, was introduced in a consistent, planned manner. When a patient made errors in his performance for a certain number of trials, for example when blind alleys were made repeatedly on the stylus maze, he would receive guidance. First, this guidance was of the verbal sort; the psychologist would point out the nature of a correct solution and urge the patient to attempt it that way. If this did not result in a correct performance, guidance in the form of overt manipulation of the patient's responses was used. For example, with the stylus mazes, the patient would be required to hold the end of the stylus while the psychologist moved it correctly through the pathways until the fudge tray was out. This type of guidance was introduced for a fixed number of trials, then the patient would be returned to trials in which he was on his own. When a problem of a certain type, say alternation of two levers on the multiple choice box, was solved only with guidance, the patient would be given another problem on the same level of difficulty. This was continued until the patient succeeded—without guidance—with a problem of that type before he was taken to the next level.

The patients did not, of course, progress with the same speed through these problems. Thus identical problem materials could not be used for all patients on any one day. After each day of the experimental period, approximately an hour was spent studying the records for each patient on that day, and drawing up plans for procedure on the following day.

During the three-month experimental period, the four patients of Group I began five days of the week with a session of prodding with some kind of problem-solving material. With the exception of one patient, all of them so far have apparently accepted the learning period, some even entering the experimental room in the morning with certain signs of eagerness. They of course varied extremely in the level of difficulty which they finally reached at the end of the three months. Some could not do the reasoning type of problems, but all got some degree of proficiency at the motor type. The one exceptional patient refused for the full three months to attempt the motor problems. Finally the experimenter spent the testing

period with the reasoning problems, after a brief attempt to get co-operation with the motor problems. This patient became an expert with ingenuity problems, dictated stories for 24 of the TAT cards, and did exceptionally well with the psychodrama problems at the end. The only type of reasoning problem which he did poorly with was the interpretation of proverbs, and he obviously realized this. While all the other patients attempted the motor problems, they varied widely in their approach-concern over making perfect responses.

Detailed learning records of the kind conventionally taken in the psychology of learning, were kept on each patient. While these data are considered to have a wealth of significant implications for the nature of the schizophrenic process, they will not be analyzed in the present paper. The purpose of this report is to present the results of an attempt to measure the over-all value of this method as a therapy in schizophrenia.

Measurements

Four different kinds of measurements were used in attempting to evaluate the effectiveness of treatment. All but one of these was made during the six months immediately following the end of the experimental period.

1. *Objective Ward Incidents.* In all psychiatric hospitals the ward folders of patients contain much written material bearing on their mental and physical progress. A great deal of this is in the form of opinions, for instance a nurse makes a statement that a patient seems more co-operative today, or that another is becoming hostile. Statements of this kind are really value judgments. Mixed in with this type of material are recordings of objective events which have an unambiguous bearing on the patients' social adjustment, at least as far as the hospital environment is concerned. Some of these objective events are positive in their implications signifying improvement; others are negative, and signify a decrement. A careful watch was kept on the folder of each patient, both test and control, during the six-month observation period; and records were kept of these objective incidents.

The ward folders of the patients used in this experiment record the following positive events: (1) Transfer to a ward where the patient could be put on outside detail, working in gardens, etc.;

(2) being granted partial privileges, including freedom of the grounds for most of the day; (3) being sent home on trial visit. The following events have been recorded as of negative significance: (1) Having a fight of serious enough nature to warrant examination by nurse or doctor; (2) receiving a short course of maintenance electric shock; (3) self-injury of some sort, serious enough to warrant a medical report; (4) destroying property, such as windows or furniture; (5) striking an aide; (6) transferral to a disturbed ward.

When a patient's folder shows neither positive nor negative events, this probably means that he was doing fairly well. Study of ward folders for this type of record shows that after an extended period of no negative events, there is usually a positive one—transferral to another ward or trial visit. The interpretation given these objective events is borne out by the fact that so far, in none of the patients studied, 36 in number, has there been both a positive and negative event recorded, although there may be as many as eight negative incidents recorded for one patient. Over a six-month period, a patient apparently either is improving or is not changing, or is growing worse. He does not change rapidly enough to show changes in both directions.

2. *Gardner Behavior Chart.* A second measurement was the G. B. C. scores, derived from ratings made by the head nurse within the week following the end of an experimental period.

3. *Occupational Therapy Ratings.* From two to three months following the end of an experimental period the chief occupational therapist filled out an O. T. performance rating scale for all 12 patients. This rating scale was a shortened form of the G. B. C., including only those traits which could be judged from behavior during O. T. It was assumed that the scores obtained in this way would correlate positively with a patient's tractability and constructive efforts in O. T.

4. *Number of Days Worked in Special O. T.* This measurement was based on records kept during the experimental period. The nurse who supervised the special O. T. with Group I and II patients made a written statement every day on the performance of each patient. These records were brief, and to the point. They named the type of material used with a patient on a certain day, and whether or not he had worked with it.

Results

At the present time three sets of 12 patients each have completed the experimental period and have been observed for six months thereafter. Ten patients of Group I, 12 of Group II, and 12 of Group III have completed the experiment. The difference in the number of patients in the groups was due to the loss of two patients in Group I. One of these, who was to be used in the first cycle, did not receive insulin because he objected violently; and, in addition, the experimenter was not certain that he would have time to process more than three in a morning. The other patient was dropped from the experimental group when it was found that the method of selection that was used to exclude subjective bias had resulted in overlooking the fact that he had been subjected to a prefrontal lobotomy.

All the patients used in this experiment were white men. With respect to work history, education, and social background they were a fairly homogeneous population. The random method of sorting the patients into three groups resulted in similar distributions of age and number of months in the hospital. Age ranges in Groups I, II, III were, respectively, 27-43, 23-42, 26-40.

The results of the measurements made with these patients were used for three comparisons. The difference between the results for Groups I and II permits an inference of the effect of the learning variable; the difference between Groups II and III isolates the effect of the special O. T. plus insulin and the concentrated attention which was necessary; a comparison of Groups I and II should indicate the effects of learning plus the special O. T. and insulin.

The hypothesis which this investigation was designed to test leads one to expect greater evidence of improvement in Group I than in Groups II or III; and since the concentrated attention and special O. T. would ordinarily be classed as favorable factors, one would expect Group II to show some improvement over Group III.

Table 1 presents the data for the measurement "Objective Ward Incidents." In this table, matched patients are in the same row. For example, Mu's match in Group II is Lu, and in Group III, Mo. Also Lu and Mo are matches for comparison of Groups II and III. Hu and Jt are matches for comparison of II and III, although there are no matches for them in Group I.

The most striking feature of this table is the obvious difference in distribution of positive and negative events over the three

Table 1. Number of Objective Ward Incidents Per Patient, and Application of the Statistical Sign Test

Incidents						Sign test		
Group I		Group II		Group III		I-II	I-III	II-III
Mu	+1	Lu	0	Mo	0	+	+	0
Ca	+1	Mk	0	Se	−4	+	+	+
Ke	0	Js	0	We	−5	0	+	+
Ev	0	Ml	−4	Ry	0	+	0	−
Wy	0	Pi	0	Md	−2	0	+	+
Ma	0	Ho	−4	Fr	−8	+	+	0
Wi	+1	Fj	0	Gr	−4	+	+	+
Da	+1	La	+1	Bu	−4	0	+	+
Ws	0	Sp	−2	Hd	0	+	0	−
Br	0	Mg	0	In	0	0	0	0
		Hu	−2	Jt	−1			0
		Lo	−5	Je	−6			0
Likelihood of this result on a chance basis						.016	.008	.226

groups. While there were four patients in Group I whose records show positive events, there was only one patient out of the 24 of Groups II and III whose file recorded one. Patient Da went home on trial visit shortly after the experimental period; the other positive events were for transferral to an outside detail ward, except for partial privileges given Ca. Patients with negative events occurred only in Groups II and III, five in one, eight in the other.

If one considers only the question of the pairings, the three columns entered in Table 1 may be prepared under *Sign Test*[9] from the three columns entered under *Incidents*. As one reads across the first line, Mu's +1 minus Lu's 0 equals +1. In the right-hand three columns, however, the numbers have been omitted and only the signs listed. A "+" is therefore entered at the top of the first column on the right. Mu's +1 minus Mo's 0 equals + which is entered in the top line of the second column on the right, and Lu's 0 minus Mo's 0 equals 0, entered in the third column. In the column I-II the difference is other than zero in six instances, and in each it is recorded in favor of Group I.

If one were to begin with equivalent groups and use alternative treatment procedures of equal virtue, chance factors would determine which member of a pair would make the better showing. The likelihood that one pair would show a difference in favor of Group I would be 1 in 2, and the likelihood that six pairs would all show a difference in this direction with no reversals would be only 1 in

2 to the sixth power or 1 to 64. This is an acceptable level of confidence. Similarly the likelihood of the seven differences in favor of Group I as compared with Group III listed in the column headed I-III occurring on a change basis would be only 1 in 2 to the seventh power or 128. This level of probability makes it reasonable to accept the present study as furnishing satisfactory evidence that the methods undertaken have therapeutic value.

In the comparison of Groups II and III, it is necessary to note the two instances in which the patients in Group III made the better showing in comparison with the five in which the reverse was true. This makes necessary a more complicated calculation. The likelihood of this occurring on a chance basis is greater than 1 in 10, and this level of significance is not satisfactory. It cannot be said that there is evidence that subshock insulin, plus the special attention accompanying the special O. T., is therapeutic without the guided problem-solving.

The outcome of similar comparisons which were carried out with the other three measurements, the Gardner Behavior Chart, ratings by the chief occupational therapist, and the number of days the patient worked in special O. T. for the first and second halves of the experimental period, are summarized in Table 2. The first column lists the four measurements; the second column itemizes the pairs of groups compared; the third column states whether the difference is favorable or unfavorable either for the major hypothesis of the experiment or, in parentheses, for the hypothesis concerning the insulin and O. T. The X's in the last three columns indicate the statistical evaluation placed on the various differences.

The group differences observed for I and II are favorable to the major hypothesis for all four measurements; the three possible differences measured between I and III are also favorable. The measurement, "Number days worked in special O. T." does not apply to Group III.

The differences as measured by Objective Ward Incidents are highly reliable between Group I and both of the controls. As measured by the other three methods the differences between I and II approach statistical significance. In these other three measurements, the difference I-III is not statistically significant.

The results obtained with the Objective Ward Incidents would alone suffice as a basis for rejection of the null hypothesis, that

Table 2. Summary of Results: Implications of Differences for Hypotheses and Statistical Evaluations

Measurement	Differences between groups	Implication for hypotheses	Statistical evaluation* Significant	Approaching Significance	Not Significant
Objective ward incidents	I-II	Favorable	X		
	I-III	Favorable	X		
	II-III	(Favorable)**			X
Gardner Behavior Chart scores	I-II	Favorable		X	
	I-III	Favorable			X
	II-III	(Unfavorable)			X
Occupatonal therapy rating	I-II	Favorable		X	
	I-III	Favorable			X
	II-III	(Favorable)			X
Number days worked in special O. T.	I-II	Favorable		X	

*If P is less than .05 the difference is considered *significant;* if P is greater than .05 but less than .10, it is *approaching significance;* if P is over .10 it is *not significant.*

**The word in parentheses refers to an hypothesis other than the major one of this experiment. In this instance the hypothesis is that the insulin and the extra attention received by Group II over that received by Group III is therapeutic.

there are no real differences between the groups. The results obtained by the other three measurements lend support to the central hypothesis.

The design of this experiment permits a test of the hypothesis that a prolonged period of intense occupational therapy plus subshock is favorable to social adjustment. If this were true, one would expect a difference in favor of Group II over Group III. The implications of the results, shown in Table 2 in parentheses, are inconclusive with respect to this comparison. For the two measurements Objective Ward Incidents and O. T. Ratings, Group II is favored; the Gardner Behavior Chart scores favor Group III. All of the three relevant comparisons are statistically insignificant.

The results of this investigation indicate that the effect of the treatment on improvement is great enough and affects enough patients so that it is measurable in small samples. Thus it can be concluded that, even though this method of treatment is relatively expensive, the effects warrant continued investigation.

General observation of the test patients, on the ward and in O. T., indicates that most of them are in better contact and more adapt-

able after the experimental period than they were before. It is believed that the real value of this form of treatment is that it improves the patient's condition to a point where other therapies can be applied, and the gradual progress of the patient toward ultimate rehabilitation hopefully continued.

Is the special attention which these patients received sufficient to explain the results? Group II was put in the experimental design to control this factor. And the answer is clearly a negative one. It might be maintained that the comparatively brief attention of the psychologist explains the results. However, several things argue against this hypothesis. One is that the special attention received in O. T., and that incidental to the insulin, were much more close and constant than that given by the psychologist. Another important point is that at the same time that the Group I patients got the attention of the psychologist, they got less of this more constant attention than did Group II. The psychologist purposely limited his contact with the patients to that of maintaining the striving necessary for learning. Very little conversation took place during the problem-solving interviews. Evidence that the interpersonal relations between the patients and the aides and nurses were much closer than they were with the psychologist was observable in the general behavior of the patients of Groups I and II after the three-month experimental period. When an experimental period was ended, the patients were reluctant to leave the special O. T. table, and were observed to be frequently moving around the neighborhood of the nurses and aides who had worked with them. They did not in any way seem to seek the company of the psychologist.

This argument that the special attention of the psychologist could explain the results of this experiment can be just as readily applied to any other form of treatment where a therapist is personally present. The only conceivable way of finally answering the question that special attention of the therapist, rather than the method of treatment, as the effective factor, is to design a situation where the therapy could be administered without a therapist. And this is hardly conceivable in many forms of treatment.

The results of this experimental evaluation of reality problem-solving as a method of treatment in schizophrenia clearly warrant a continuation of the investigation. As is usual in any research project a pursuit of one problem always turns up others, which

determine the direction of future investigations. The importance of studying the effects of several variables on this method of treatment are fairly obvious. Probably the first thing to study should be the condition of the patient. What type of schizophrenia seems to profit most, catatonic, paranoid, or hebephrenic? Does the degree of the patient's regression have a relation to his potential for improvement by this method?

Another less obvious variable is the learning material used. This of course is a collection of many variables, including the nature of the problem materials, their difficulty, and the use of guidance. When and to what extent should the patient be made to struggle for success, and when should he be guided if the problem seems to be too difficult? The present plans for the immediate future are the continuation of the study under the same design. Three additional cycles of 12 patients each should permit (1) a test of the validity of the results reported herein, and (2), with an increase in number of patients, a subgrouping of the test patients to determine which type, if any, seems to profit most from the treatment. Further investigation will not require the use of control groups, which are not getting the treatment, since it can then be safely assumed that the treatment is valuable. This will greatly reduce the cost of the investigation per patient treated.

Summary

Ten chronic schizophrenic patients were subjected to individual problem-solving sessions five days a week for three months. The learning process was motivated by insulin-produced hunger. The patients were observed during a post-experimental period of six months for the purpose of evaluating the effects of treatment on social adjustment. Adequate control groups of matched patients were used to isolate the effect of insulin and special attention was given the patients in occupational therapy. It is concluded that guided problem-solving, motivated by hunger, is an effective method of improving the social adjustment of chronic schizophrenics.

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THE DIAGNOSTIC PSYCHOLOGICAL REPORT*

BY ROBERT S. MORROW, Ph.D.**

The contribution that the psychologist makes in the application of projective methods to therapy depends essentially on how the psychiatrist or psychotherapist understands and accepts the information. An attempt will be made in this paper to indicate the ways in which the useful information of the clinical psychologist may be conveyed—rather than to discuss what is conveyed.

In emphasis on testing techniques and their application the methods of reporting psychological findings have been virtually neglected by our major training sources. Thus, of the two universities which serve as the main institutions for training clinical psychologists in the New York City area, one reported that no special training was given in report writing, while the other reported devoting only two sessions as part of a general orientation program. In addition, the other important vehicle for training besides the university course, the standard textbooks in clinical psychology, contains nothing about writing reports, although most of the texts have sample reports as models—but without needed explanations.

The subject of report writing is becoming a matter of greater importance and more intense interest, however, as seen from the recent appearance of several publications. Among the earliest articles is one by Taylor and Teicher[1] in which they emphasize the point that the request from a psychiatrist for a "psychological work-up" involves a group of separate problems, each requiring different tools and focus, as well as distinct methods of reporting data. They give outlines for presenting these different types. Holzberg and his colleagues[2] have enumerated important principles to consider in presenting psychological reports, and they recommend formal training in writing reports.

Sargent contributes to the thinking on report writing in two separate ways. In one instance she has worked out, together with Karl Menninger and others,[3] a "schema for psychological examina-

*Presented at the 1953 annual meeting of the New York Chapter of the Society for Projective Techniques.

**The writer wishes to acknowledge indebtedness to Dr. H. L. Flowers, chief of the neuropsychiatric service of the Veterans Administration Hospital, Bronx, N. Y., who, in creating a genuine team relationship, has been most helpful in the formulation of the ideas expressed here.

tion reporting." In a separate article[4] she presents as "an experiment in communication four different reports for the same test information from one patient, each report conveying the same information but in different ways, according to purpose, questions asked and technique of communicating.

Other evidence that this problem is receiving the further attention of clinical psychologists can be seen from such material as Foster's brief note,[5] in which he recommends avoiding certain undesirable aspects of the routine psychological report; from the appearance of several mimeographed outlines on test communication; and from increasingly frequent discussions, as well as reports of contemplated studies, such as the one now under way by Grayson and Tolman in which they have asked for a "sample best report" from various centers.

It has been the writer's good fortune to be associated with a very competent group of staff and trainee psychologists, who have labored long and hard with this problem of psychological reporting. It should be borne in mind, therefore, that what is noted here is tantamount to a majority report from the Bronx Veterans Administration Hospital psychologists.

As a result of concern with the problem of psychological communication, the writer recently undertook a survey of the psychiatrists and psychologists in his own hospital. He attempted to ascertain from the psychiatrists what they wanted in psychological reports and how they used them, and also asked the psychologists what information they desired from the psychiatrists and what difficulties they encountered in formulating reports.

It was possible to ask 20 of 25 resident physicians the two questions for psychiatrists. There were 16 responses. As one would expect, there was considerable variation in the feelings expressed as to the usefulness of psychological reports. Since these residents depend considerably on the psychologists, they all accepted the diagnostic function as generally useful but disagreed enormously as to what they wanted included in the psychological report, and, also, as to how they use a report. Two wanted only psychometric data, such as IQ; five wanted essentially "objective" diagnostic information, differential diagnosis primarily, with some here expressing the feeling that such diagnosis should be of the "blind" sort. The remaining eight wanted only dynamic personality de-

scriptions, including data on preoccupations, interpersonal relations, unconscious needs and aspirations, etc.

As to how psychological information is used, this seems to depend on such factors as how much the psychiatrist knows about psychologists and projective tests, as well as on the purpose of the psychiatrist's request for a test. This purpose, in turn, is related to the current activities and interests of the psychiatrist. That is, four of the five psychiatrists wanting only differential diagnosis were at that time working exclusively with shock therapy; and so they wished to know whether patients, on the basis of psychological test findings, were candidates for their therapy. It can readily be seen that the usual, dynamically-oriented report would generally be a waste of time and energy here. Almost all of the eight psychiatric residents requesting dynamic formulation had more extensive experience with psychologists and their techniques; and they were currently doing some kind of psychotherapy. They stated in general that the dynamically-oriented report was used for rounding out the personality picture of a patient, as well as for offering leads to the source of conflict, to defenses used, degree of reality testing, the patient's assets, prognostic indicators, etc.

It is perhaps to be credited to the attitude of mutual respect which the psychologists of the hospital have with most of the psychiatrists that they find the psychological examination a unique and valuable contribution to diagnosis and treatment. One of the residents seemed to represent this view very well when he stated: "I like to watch the tests given. The patients are under a more stressful situation whereas the psychiatric interview is given in a more permissive setting. In addition the patient is not as guarded or controlled in this unfamiliar and unstructured setting, so that you get much deeper and more valuable information this way." The writer should like to add that he devotes six to eight hours in orientation lectures to the new residents and spends six months to a year in weekly seminars on psychological examinations with the second-year and third-year residents.

This preliminary survey seems to indicate that the more experience the psychiatrist has with clinical psychology, the more he tends to use it, and the more effectively he tends to use it. In other words, the more he knows about psychologists and their projective techniques, including their limitations as well as contributions,

the better is the chance that he will use the psychologists' work fruitfully in therapy.

In a similar survey, 15 of the staff and trainee psychologists were asked to describe the information they would like to receive on the referrals for examination and to describe the difficulties they have in formulating their reports. There was much more agreement here than among the psychiatrists. This almost unanimous agreement undoubtedly derives from daily confrontation of this problem, together with the frequent discussions that have been held regarding psychological reports, especially in the training program.

Practically all the psychologists felt that their difficulties in writing reports were related to deficiencies in the consultation referrals. The chief criticisms of the referrals were that they were too general and too vague, as for example, merely requesting "psychometrics" or "personality evaluation." Such requests, as one should expect, are hard to meet in a meaningful way and result most often in somewhat desperate attempts to anticipate the needs and interests of the psychiatrist. As one works more closely with a particular psychiatrist this anticipation of needs undoubtedly becomes easier. The vague psychiatric request inevitably results in stereotyped jargon-ridden psychological reports.

Almost all of the psychologists wished they could avoid guessing and felt that they could contribute far more meaningfully if the psychiatrist would make specific statements covering the major problems and questions for the psychologist. Specific questions make attention possible to the psychological materials which are most pertinent to the issues involved. Moreover, they would increase the efficiency of the psychologist, since so much time is unfortunately wasted in floundering around in search of a peg on which to hang the psychological formulation. Too often, a good part of the psychological report, which is so painfully worked out, is not used, and perhaps not even read, by the psychiatrist.

Making a referral more pointed makes the psychiatrist's job more difficult because it requires an attempt on his part to formulate a case before psychological consultation. He is compelled to think more profoundly about the patient and his problems. He is rewarded, on the other hand, by a report which answers concrete and practical questions. The alternative of this is the frequently found "shotgun" or omnibus description, which attempts to an-

swer every conceivable problem so that nothing is missed. Such reports are couched inevitably in broad generalizations, which are aimed at giving interesting dynamic formulations, but general experience with them is that they unnecessarily waste the time and energy of both psychologist and psychiatrist.

Many psychologists—in consequence of having to write these general reports for a variety of psychiatrists and covering a variety of situations—develop outlines of topics and areas which they regard as important; and each patient's description becomes confined within this rigid framework. As can readily be seen, this tends to lead toward the psychologically-oriented type of report rather than to one that is patient-oriented. The commonly heard criticisms of the psychological report seem directed mainly against these mechanical, stereotyped, lengthy and omnibus types of psychologist-oriented reports.

Some of the psychologists questioned, however, felt that the clinical psychologist was an important member of the hospital team and that his ego and professional needs justified his working independently. They implied that if they had worthwhile contributions to make they should be free to make them without direction from the psychiatrist as to what questions to answer for him or what areas to cover. That is, once the patient was referred to the psychologist for examination, the tests, the length of his report, his philosophy of therapy and his orientation, as well as his use of psychological jargon, were matters of his own professional concern.

This argument seems to lose sight of the fact that the sole justification for the psychological consultation is its usefulness to the therapist. The psychological report should not be made to carry any burden other than maximally effective communication about the patient to the therapist. Too frequently, the report serves as an exercise in narcissism, or as a weapon in an interpersonal or interprofessional power struggle. One frequently sees a report, full of profound and pyrotechnical formulations, but which loses sight of the patient as the primary objective. Whatever the therapist's limitations, the psychological report is worth no more than the use to which the therapist can put it.

In answer to criticisms of esoteric or technical terminology in psychological reports, especially the use of such psychoanalytic terms as "phallic mother," "pre-genital fixation," "unresolved

Oedipal conflict," those who use such phraseology defend themselves by stating that they are using correctly "the language of the trade" and that therapists who do not accept or understand it are unfortunate objects requiring pity, further training or psychoanalysis. This immature attitude is reminiscent of the dialogue in *Through the Looking Glass,* where Alice criticizes Humpty Dumpty for pompously misusing words: " 'When I use a word,' Humpty Dumpty said, in a rather scornful tone, 'it means just what I choose it to mean neither more nor less.' 'The question is,' said Alice, 'whether you can make words mean so many different things.' 'The question is,' said Humpty Dumpty, 'which is to be master that's all.' "

It should be remembered that technical words or phrases may mean many different things, which often require further explanations or meaningful contexts. What is more important than impressive language is to know how the term describing or explaining the personality is demonstrated by the patient and how the patient handles situations. This frequently involves the question of using evidence. The writer strongly supports the use of documentation, because quoting a Rorschach response or TAT story frequently serves as a more eloquent description than the most carefully written report.

The description of the diagnostic work of the clinical psychologist at the Bronx Veterans Administration Hospital should serve to illustrate several ways in which this problem is handled, as well as to offer possible material for provocative subsequent discussion. This is a general medicine and surgery hospital treating 1,500 patients. The clinical psychology section is under the chief of the neuropsychiatric service. There are, including the writer and a speech pathologist, seven staff and 12 trainee psychologists. Each staff psychologist, together with his trainees, is responsible for a major neuropsychiatric subdivision, and each trainee rotates during the year through each one. Thus there is a psychologist regularly responsible for the psychological work of the two neurology wards of 80 patients as well as for the neurosurgery patients; one psychologist regularly responsible for the 40 patients on the locked psychiatric ward; one for the 80 patients on the open and semilocked psychiatric wards; one for the out-patient department and mental hygiene clinic; and one for the psychosomatic ward of 20 patients, as well as for the rest of the hospital.

Since each department or service has specific problems, it has been found that the focus of each of the hospital's services is quite different from those of the rest. A regularly assigned staff psychologist gets to understand the special needs of his group and assumes responsibility for handling them properly. He can thereby apply his techniques, including his report, in the most helpful way. Thus the same psychologist who is responsible for both the outpatient service and the mental hygiene clinic is confronted almost routinely in the former instance with the primary problem of differential diagnosis, in order to help determine whether the patient should be hospitalized, and, if so, whether an emergency is involved; whereas, in the latter case the patient has already been accepted for psychotherapy, making the psychologist's problem in general that of giving dynamic personality descriptions, emphasizing information which the therapists will find useful.

This should be understood more clearly from a general description of what goes into most of the types of reports which have been evolved in this hospital. It should be remembered that there is nothing rigid about any of this procedure. The result is something that is now regarded as very effective, since the techniques have been developed from the needs which the psychologists have recognized from their participation in the procedures on the wards. The writer is impressed with the fact that this has resulted in a minimum of complaining about the psychological reports and, more important, it is felt that the results are closer to the objective of patient-centered reports.

It has been found that the neurologist and neurosurgeon chiefly want information about intellectual and memory functioning, together with distortions in personality which are very useful for diagnosis of structural pathology or for differential diagnosis between organic and functional conditions (i. e., symptomatic epilepsy vs. hysterical epilepsy; hysterical components relative to the absence of organic findings in low back pain, etc.). What they generally want is the IQ; the estimated comparison with premorbid functioning; memory function and areas of difficulty; concrete vs. abstract thinking; aphasia and other language problems; and personality functioning only as relevant to these. The neurologist is hardly interested in the problem of latent homosexuality in his patient if it is not directly related to the patient's condition. If, how-

ever, the indication of characterological difficulties is found to contribute to the symptomatology, as in a hysterical overlay of an organic condition, the neurological service—which is psychologically sophisticated—welcomes this contribution to the diagnostic and therapeutic management of the patient.

The reports for the psychiatrists vary according to the particular services which are involved. The locked psychiatric ward is primarily for psychotic patients, and the psychological contribution for the psychiatrists concerned is in differential diagnosis between psychosis and other conditions. Many questions are frequently asked, however, about the indications for shock therapy, prognostic signs, personality assets, suicidal and homicidal preoccupations, evaluation of therapy through periodic comparisons, signs of improvement, etc. Where the more active psychotherapy is done, as in the open psychiatric wards, as well as in the mental hygiene clinic, the dynamic evaluation has become almost routine procedure, including structure and organization of the personality, characterological deviations, unconscious wishes, aspirations, frustrations and conflicts, sexual role and preoccupations, defense mechanisms, attitudes toward people, resistances, etc. For the psychosomatic patients, the psychiatrists and internists are interested in knowing differential diagnosis in addition to the usual dynamic formulation, and, also, psychotherapeutic prognosis.

In the psychologist's report there is always an effort to write according to the training and orientation of the psychiatrist concerned and the needs of his patient. One tries to take into account factors such as the knowledge which the psychiatrist has about projective techniques, and as to whether he has a therapeutic system to which the tests and other data can be applied. Every conceivable therapeutic and analytic school and every stage of training seems represented in the psychiatric service.

Obviously, to get the most out of the psychologists' reports, psychiatrists need educating in the projective methods. It should be recalled that in the informal survey at the Bronx Veterans Administration Hospital, it was found that the more experience the psychiatrist has with clinical psychology, the more effectively he tends to use it. The psychologist, on the other hand, assumes the responsibility for communicating a meaningful and useful report. To make such a report truly patient-oriented, the clinical psychologist

must give up his Humpty Dumpty attitudes of striving to be the master of words, while the psychiatrist must in return make a sincere effort to meet the psychologist half way, making clear what he wants and learning to understand and respect the psychologist's methods and techniques.

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THE MENTAL PATIENT LOOKS AT "THE SNAKE PIT"*

BY CHESTER C. BENNETT, Ph.D., AND JOHN ARSENIAN, Ph.D.**

The motion picture *The Snake Pit*† is based upon the experiences of a mental patient. It follows with considerable fidelity the autobiographical testimony of a patient which appeared first in book form.‡ Despite its unusual theme, the picture was favorably reviewed and commercially successful. It is the writers' impression that the film has been generally acclaimed by clinicians, in the belief that it enlightened as well as entertained the public, although no systematic audit of its educational impact has been reported.

It is the purpose of this paper to evaluate reactions to the film, *The Snake Pit,* of a specific audience—an audience of mental patients. Each week a movie is included in the regular program of entertainment for patients at Boston (Mass.) State Hospital. The selection may be comedy, drama, mystery, or any of the better pictures. One week it was *The Snake Pit.* No special publicity accompanied this particular film. Like other pictures, it was shown several times in recreation halls and ward rooms throughout the hospital. The opportunity to attend was available to most patients. None were urged; none were excluded for reasons specific to *The Snake Pit.* The writers have no way of estimating the effect of self-selection; and, of course, the audience omitted certain groups of unmanageable and bedridden patients. On the other hand, some of the better adjusted patients on work detail or ground parole may have been otherwise occupied. About 25 per cent of the patient population saw the picture, an audience broadly representative of hospitalized psychotics.

The decision to show *The Snake Pit* was greeted with misgivings by some of the staff, and applauded by others. Actually the pa-

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†Twentieth-Century-Fox Film Corporation, 1949.

‡Ward, Mary Jane: The Snake Pit. Random House. New York. 1946.

tients seemed to take the experience very much in their stride. The projectionist and other observers at the time noted no unusual excitement or restlessness in comparison with patients' reactions to other movies. A few refused to see the film, or walked out on it. One stamped out muttering protests but later returned to the hall, apparently unable to take it but equally unable to "let it alone." Two patients were reported more resistant to shock treatment following the picture. On the other hand, appreciation was volunteered by several patients. A nurse reported hearing considerable good-natured banter, related to incidents in the film, on her ward of female patients. These are anecdotal impressions of interest chiefly for their lack of drama and consensus. In gross behavioral terms, the patients responded to *The Snake Pit* much as they have to other movies, and for that matter much like a normal audience.

The writers' interest, however, was in the subjective meaning, and, inferentially, in the therapeutic value, of this experience for mental patients. On the naïve assumption that one could learn how the patients felt by asking them, the writers developed a structured interview which was administered by clinical psychology students from Boston University. In the absence of any rationale for sample selection, the audience itself being non-parametric, interviews were conducted at random with patients who had seen the movie. The sample intentionally omitted tubercular patients and unintentionally slighted the chronic female patients. It is possible that the interviewers tended to make contact with the more articulate, presumably less sick, patients. However, the group included some who were grossly disoriented; and all such interviews were tabulated, even though incomplete, to minimize any favorable bias. Interviews followed the movie as soon as possible and all were within the week before another film had intervened.

The writers are reporting responses of 156 patients—approximately 20 per cent of the total audience. Probably the representativeness of such a sample is best defined by its own dimensions. The group was 65 per cent male, 35 per cent female. The ages ranged from 18 to 90, with a median just over 40. Figures for duration of illness ranged as high as 40 years, with a majority of 53 per cent under five years, 25 per cent over five years, and 22 per cent unknown. These data were based on recorded dates of hospitalization, rather than onset, and certainly underestimate the

total patient-years of mental illness. No less than 45 different diagnostic labels were employed in cataloguing the group.

To make this dimension comprehensible, five general categories were created: schizophrenic disorders—present in 58 per cent; affective disorders—21 per cent; psychopathic problems, including alcoholism—19 per cent; general paresis and other organic disorders—7 per cent; senile and sclerotic—6 per cent. These subgroups overlap and exclude 12 per cent whose diagnoses were not ascertained. Another diagnostic evaluation is implied in the administrative grouping of these patients in different buildings as acute (35 per cent), disturbed (38 per cent), and chronic (27 per cent). At least 37 per cent of the subjects were receiving psychotherapy, either individual or group, and 24 per cent were receiving, or had recently received electric shock treatment.

These are minimum estimates, based on positive information. Additional patients were probably receiving active treatment, but the information eluded the writers. It was also difficult to obtain estimates of prognosis. After scrutinizing records and interviewing ward physicians, the writers must report 31 per cent of prognoses as unknown. The modal prognosis was "poor" (33 per cent). The doctors gave 21 per cent a qualified, fair, or "guarded" prognosis. Only 15 per cent were credited with a favorable prognosis even at the symptomatic level of temporary remission or ground parole.

It is evident that this is a discussion of a very heterogeneous group of mental patients and a very sick group. An intragroup comparison of males and females consistently favored the female subjects. As a group they were younger, more recently ill, more often classified as acute rather than chronic patients. They included more affective and fewer organic disorders. They were receiving more active treatment, both shock and psychotherapy, and were more often credited with favorable prognoses. Percentage differences between the sexes for all these factors were significant at the .05 level—most of them at the .01 level. Except for the limited representation of chronic female patients, the sample as a whole was a plausible microcosm of hospitalized psychotics.

As a supplementary venture, the project polled the reactions of a group of student nurses who witnessed *The Snake Pit* in company with the patients. There were 26 respondents who answered the interview questions in writing. They might be thought of as con-

trols, assuming that this group controlled at least the factor of mental disorder. However, they were not a random population nor were they representative of commercial movie audiences. Their perceptions of *The Snake Pit* were affected by their own specific biases—professional, youthful, and feminine. Their responses constitute an interesting opinion sample in its own right —to some extent useful in establishing a baseline of normality with which the patient-reaction can be compared.

The interview began with a request for an over-all first reaction, "What did you think of *The Snake Pit?*" Patient responses varied from "Marvelous" to "Horrible" to *"Corpus Christi."* One-third of the group failed to communicate a reaction that the writers could classify. Interpretable replies, however, were positively toned rather than negative in a four-to-one ratio. This ratio held for males as well as females. Confronted by the same question, the student nurses showed one difference which proved characteristic. They were more articulate. Only one gave an ambiguous reply. The others, expressing a first reaction, showed the same four-to-one ratio of positive response that was obtained from the patients.

In reply to the next question, 27 per cent of the patients said they had either seen the movie before or read the book or the *Readers' Digest* condensation. (The book is readily available to patients in the hospital library.) Additional patients reported some advance knowledge about the film, and it is interesting to realize that a sizable block of the audience attended voluntarily, knowing what was to be expected. Of the student nurses, 62 per cent reported previous familiarity with *The Snake Pit.*

Asked what the picture was about, 50 per cent of the patients clearly identified the motif—it was about a mental patient, mental hospitals, "a hospital like this," etc. Asked how the picture ended, 43 per cent of the patients made some reference to the recovery or discharge of Virginia (the central patient in the film). To the next question, "What was wrong with Virginia?" the modal answer specifically mentioned mental illness; and, with the addition of "nervous breakdown," "guilty conscience," etc., 58 per cent of the patients gave appropriate answers. Three patients tried to label the diagnosis. Only 6 per cent told the writers they saw nothing wrong with Virginia.

These questions were introduced as an exercise in reality testing. The writers conclude that the patients not only saw *The Snake Pit;* they understood the gist of it. Roughly, half of the respondents were able to report their recognition that the film dealt with a mental patient, hospitalized, treated, and eventually released. Several likened their own situation to the picture. As might be expected, the student nurse response was more consistently appropriate. How much the difference represents perceptual failure among the patients, and how much failure in reporting what they saw, the writers cannot say.

At this point the interview asked, "Is the picture true—do these things really happen?" Only three patients (and none of the student nurses) flatly rejected the essential plausibility of the film. One patient and two student nurses called it exaggerated. There were other qualified replies—it was true in part or might be true for some people. Omitting these answers, 67 per cent of the patients and 77 per cent of the student nurses accepted *The Snake Pit* as essentially a true story. As many as 18 per cent of the patients personalized their reaction—"It was like my own case, like this hospital, I've seen it happen."

Asked to identify the most impressive scene, the patients gave assorted answers. The modal response (11 per cent) referred to the electric shock scene which shows Virginia being prepared for EST, omits the convulsion, and dissolves into a montage of dials, switch buttons, flashes, and faces in agony, supported by a dramatic crescendo of music and noise. The student nurses were most often impressed (23 per cent) by the scene in which Hester, a mute patient, speaks her first word to bid Virginia good-bye. This scene rarely impressed the patients. The student nurses were also impressed (19 per cent) by the title scene in which Virginia—returned to the disturbed ward as a disciplinary measure—fantasies herself in a pit surrounded by writhing snakes. This episode was named by a small group of patients (4 per cent) with a significant predominance of females. Perhaps sensitivity to this scene is sex-determined.

The next question, "What lesson does the picture teach?" proved difficult for the patients. The writers were told by 7 per cent that they saw no lesson and many others failed to respond or gave vague or irrelevant replies. However, 39 per cent were able to attach an appropriate moral. Reference to the recoverability of

mental patients, presumably the ideal answer, was made by 14 per cent, a few of them couching it in personal terms—"I can get well, there's hope for me." Other responses of particular interest emphasized that the patient must help himself on the way to recovery, that "we must face our problems," that mental illness can originate in childhood, and that it can strike anyone. Among the student nurses, 77 per cent were able to identify an educational value in the picture, 46 per cent making some mention of the recoverability of mental patients.

Asking respondents whether the picture left them encouraged or discouraged, the writers received a good many ambiguous answers, but 52 per cent of the patients expressed an attitude. This can be summarized by saying that they felt encouraged in a two-to-one ratio. The modal reason for encouragement was seen in the recovery of Virginia. Most of the discouraged patients failed to give their reasons. The student nurses, with fewer ambiguous replies, expressed encouragement in an eight-to-one ratio. In this respect the film appears more acceptable from the professional than from the patient viewpoint.

Asked how the picture might be improved, about 20 per cent of both groups, patients and student nurses, could see no need of improvement. Only scattered positive suggestions came from the male patients. Suggestions from the female subjects referred most frequently to the portrayal of nurses in the film (13 per cent of female patients; 38 per cent of student nurses). The sex difference is statistically significant and the student nurses were especially sensitive to the unsympathetic representation of their profession.

The next several questions dealt with particular kinds of responsiveness to the movie. About 40 per cent of both patients and student nurses were reminded of someone they knew by a film character. Associations were made to patients and to professional personnel. Six patients admitted they were reminded of themselves. Of the patients, 60 per cent felt sorry for someone, usually Virginia or other patients. The sympathies of student nurses went first to Virginia's husband, with Virginia herself a close second. Asked if they felt "mad" at anyone, 25 per cent of the patients gave affirmative replies; 85 per cent of student nurses. The irritation of student nurses was directed chiefly toward the nurses in the film. Two-thirds of the patients were able to name a best-liked

character—most frequently Virginia. With the student nurses, the handsome Dr. Kik of the film wins the popularity contest hands down (85 per cent).

Toward the end of the interview the patients were asked, in substance, whethey they thought *The Snake Pit* should be shown to mental patients. Only 10 per cent said no. Favorable answers came from 68 per cent. Thus by nearly a seven-to-one ratio, the patients endorsed the experience they themselves were having. One considered the film appropriate for patients but did not think it should be shown to the general public. Presentation to patients was supported by 84 per cent of the student nurses with no dissenting opinion. The remaining answers were ambiguous. By a six-to-one ratio, the patients who expressed an opinion were glad they had seen the picture. Half of them said they would like to see it again.

This overview of the data aroused the writers' curiosity about specific subgroups of patients. What were the reactions of the sickest, for example? Culling the papers which included bizarre and autistic responses and those with so little contact that very partial interviews were obtained, a group of 49 (31 per cent) were assembled who were significantly different from the remainder as to chronicity, length of illness, and prognosis. The group was disproportionately male. These patients tended to be less articulate than most and, in particular, were unable to find a "lesson" in the picture. Yet even here the first reaction was four-to-one positive rather than negative. They felt encouraged rather than discouraged, by a three-to-two ratio. The tenor of opinion, when obtained, was much like that of the sample as a whole.

At some point in the interview, 66 patients (42 per cent) expressed a definite identification with the picture in terms of "like my case," "like this hospital," "like the doctors here," etc. The writers wondered how these more fully identifying patients would react. This group was disproportionately female, but otherwise similar to the total sample in chronicity, length of illness, diagnosis and prognosis. They too gave a three-to-one positive first reaction and expressed encouragement in two-to-one ratio—proportions comparable with the sample as a whole. They were, however, considerably more articulate and productive in elaborating opinions.

Another selected subgroup consisted of 60 patients (38 per cent) who specifically mentioned recoverability from mental illness—

"Virginia recovered," "I can recover," "patients do get well," etc. Here, the writers found a distinctive group tending to acute rather than chronic illness, of recent onset and with hopeful prognosis. They expressed a positive first reaction five-to-one, and encouragement rather than discouragement six-to-one. They were more articulate in attaching a lesson to the picture. In most of these respects, the deviance of this group was statistically significant.

Contrasting attitudes were expressed by a small group of 37 (24 per cent) who in one way or another referred to mistreatment of mental patients, saw Virginia as mistreated, or criticized procedures at Boston State Hospital. None of the writers' criteria of severity of illness distinguished these patients, but they were found giving *negative* first reactions rather than positive—four-to-three, and *discouraged* rather than encouraged—three-to-two. It would appear that rejection of the movie was often associated with a generally negativistic attitude about what happens to mental patients.

Confronted by reports of two patients more resistant to electric shock therapy following the film, all specific references in the patient interviews to EST were scrutinized. In several instances, the EST scene was merely noted as an impressive scene or an important episode in the development of the story. Three patients criticized the shock scene from a technical standpoint, e. g., the clamps were too big. Eight patients were clearly distressed in relation to EST. "They didn't have to show shock. It's the same category as death." "It gave me the chills. I've had it." "I was disgusted with it. The head nurse was afraid to turn the switch to the right amount. Oh God, her temples." One patient said definitely that the picture "taught me to fear shock." He felt seeing the shock scene would have a bad effect on other patients. On the other hand, one patient felt that the movie showed how patients can benefit from EST and that it should be seen specifically by those receiving such treatment. Four others expressed clearly positive attitudes, e. g.: "It taught me that patients can improve through treatment, especially EST." It is evident that the group attitude relative to EST was ambivalent. The movie seemed to disturb some patients while reassuring others.

Indeed, the findings of the survey in general are characterized by ambivalence. *The Snake Pit* has numerous and complex stimulus values. It was presented to a confused, distortion-prone audience. It is not surprising that the total response was complex and

full of inconsistency. Individual patients criticized the movie in emphatic terms and then told the writers it left them encouraged and should be shown to other patients. There were those who seemed to miss the whole point of the picture, yet called it enjoyable, encouraging. Some very intelligent interpretations of the film came from patients who found the experience as a whole distressing. It is unfortunate that the full flavor and variety of individual reactions cannot be conveyed. Psychotherapists have suggested that the interviews would be diagnostically and prognostically useful in the individual case records.

The intensity of responses suggests that *The Snake Pit* made a deep impression on many of the subjects. They were certainly confronted by a tailored opportunity to identify. Some did so quite consciously and were able to describe the experience as reassuring. Others were emotionally affected to the point of confusion. No doubt the indifference expressed by some respondents, and the autistic digressions of others, represented defense against too much involvement. A small minority of subjects seemed genuinely unaffected by the picture—"It was just another movie."

There were few patients, really very few, who represented themselves coherently and consistently as adversely affected. To quote one example, a psychopathic female: "I think it is terrible. How can you forget your past if they bring it back. I cried all night. It gave me a setback." Despite these isolated cases, it was the writers' impression, supported by the statistical analysis, that the presentation of *The Snake Pit* to an audience of mental patients did far more good than harm. The majority of responses to the interview were consistently positive, and a good share of the remainder were noncommittal. The writers could quote patient after patient who felt benefited and was able to make his testimony convincing. Skeptics may argue that the mental patient is in no condition to interpret his own reactions, but the writers find it hard to believe that patients who could say that they were glad to have seen the picture, had learned that patients do recover, felt encouraged, and would recommend the film for other patients, were being subjected to a damaging or untherapeutic experience. It was easier to believe that the subjectively distressing experience reported by some patients might well be used constructively by a competent psychotherapist to the patients' eventual benefit.

In conclusion, the survey confirms the wisdom of the hospital administration in bringing *The Snake Pit* to an audience of mental patients. In all probability, the picture scarcely disturbed the autistic preoccupations of some patients at all. To most of them, however, it was a significant experience, by their own report predominantly satisfying and even therapeutic. Realizing that the writers are calling upon the findings to validate the technique, they believe the survey demonstrates the sapience of psychotic opinion. By and large, the subjects knew how they felt and reported it. Since mental illness is very much a matter of how patients feel, it might clarify many of our clinical problems to let them speak for themselves.

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"ON-THE-SPOT" PSYCHOTHERAPY IN A CHILDREN'S INSTITUTION*

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Introduction

The role of the psychiatric social worker in the organization of diagnostic and therapeutic services in a children's institution has often been discussed. Little attention has been given to this worker's responsibility for handling emergencies where a problem arises from a recognized psychiatric disturbance of the child. This problem, however, has been of significant concern to those who work at Children's Center.

Children's Center of the New York City Department of Welfare is a congregate institution for 365 dependent and neglected children, from two to 16 years of age. It is an interracial, nonsectarian, publicly-operated shelter, which maintains a psychiatrically oriented program in which maximum permissiveness within definitive limits of control is practised. The children under care come largely from "deprived" home situations, where they and their parents have had to face frustration after frustration. The center admits all types of dependent and neglected children except those diagnosed as grossly mentally deficient or psychotic, or those adjudicated delinquent. Because of lack of other facilities, prepsychotic children or those just coming out of psychotic episodes, have to be admitted from time to time. In such an environment, where many children have to remain for months, and some for several years, until they can be removed to permanent settings, frequent and acute emergencies arise, which demand immediate relief.

Prior to the reorganization of the program under the direction of Mr. John J. Murphy, executive director, and the establishment of the psychiatric services, offensive acts of children, such as outbursts of rage, physical attacks on others, destructiveness, running away, and attempts at suicide, were principally dealt with through the administrative device of removal of the children, either to a psychiatric hospital, or to a shelter for delinquents through the Children's Courts. Thus, the anxious, frightened, insecure child, already seriously damaged, had to face another experience, interpreted as punishment and rejection. For the past three and a half

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years, however, an increasing number of offensive acts have been handled from the outset by the psychiatric social worker under the direction of the psychiatrist in an attempt to prevent the development of a pattern of delinquent behavior.

In this paper, the writers will try to describe what is being done at the Children's Center. To illustrate, they will use pertinent instances of acute emergencies. Treatment is based on a co-ordinated plan, including work by the psychiatric social worker with groups and individuals, and, if necessary, individual psychiatric treatment by the psychiatrist. It involves the counselor staff and all others having direct contact with the children.*

Case Material

Case of Joan

In July 1950, Joan, a nine-year-old girl, was placed at the center through the Children's Court. Extremely rejecting of Joan, the mother had initiated court action, claiming that the child stole, remained out late, and had sex intimacies with boys. Investigation disclosed that the mother was neglectful and an improper guardian. The child, herself, accused the mother of committing acts of prostitution in her presence. (Later, this mother was stabbed and killed by one of her paramours.) After the court had ruled the mother to be unfit, placement was arranged at Children's Center for Joan, whom the mother always called the "bad child," and for her older brother, Frank, "the good child."

From the very beginning, Joan acted out her problems, through aggressive, hostile behavior toward counselors and other children. One morning, shortly after her admission, Joan left her dormitory and appeared in the social worker's office, upset and angry. She accused her counselors of mistreating her and declared the other children were mean to her. It was apparent that Joan was re-living the home situation of sibling rivalry and displaying the feeling that mother figures are abritrary, violent, and rejecting. In culmination of her rage and despair, Joan declared that she would

*The setting of the shelter and its philosophy were described in detail in a paper "Preliminary report on the psychiatrically focused program of a temporary shelter for dependent and neglected children," by John J. Murphy, J. Andrew Simmons, Wilfred C. Hulse and Mary Decorato Vergara, read at the 28th annual meeting of the American Orthopsychiatric Association in Detroit, in February 1951. This paper was published in the Journal of Child Psychiatry. Vol. 2, Sect. 3.

run away from the center. The worker showed sympathy and acceptance toward the child's conflict and said she could well understand that Joan would not want to return to the dormitory. Since Joan wanted to run away, the worker, demonstrating that she would not abandon the child, offered to go with her.

Joan and the social worker left the institution together, and the worker permitted the child to take the lead in the ensuing situation. Despite complete freedom of action, the child did not attempt to run away or go to her home, which was within walking distance. Instead, she circled the block on which the institution is located, all the while engaging the worker in light conversation, deriving great reward from the companionship and attention given to her. After circling the block three times, Joan spontaneously stated it was time to go back, as the worker had to return to work. Upon re-entering the institution, and without prompting, the child returned to her dormitory.

This was the beginning of a therapeutic relationship which has continued for over two years, during which the child has brought to the surface a great many of her early childhood conflicts, anxieties, sexual confusions, and guilt feelings. The child is greatly improved. The original diagnosis by the psychiatrist of "severe anxiety state with acting out" was modified to "character neurosis of moderate degree" as the child is now entering adolescence.

Case of Alice

As Joan tried to escape her problems by walking out of Children's Center, Alice tried to escape by walking out of life. In October 1948, Alice, aged 10, was remanded to the center by the Children's Court, where she herself had gone to complain of gross mistreatment at home. Alice's life had been one of confusion, and uncertainty. As a child born out of wedlock, she resented living in a home where younger half-siblings had close and continued contact with their father. Alice felt different, unwanted and unloved by everyone. The mother, diagnosed as a mental defective, often released uncontrollable hostility toward Alice, as well as toward Alice's father in the child's presence. Removal from home, which Alice herself had requested, intensified her anxieties and guilt. Hostile feelings toward the father who refused to acknowledge her, toward the mother who was rejecting and inadequate, and toward the stepfather who favored his own children, were carried over into

her relationship with the counselors and the psychiatric social worker.

During the first few weeks in the center, Alice was acutely upset, her anxieties being manifested by wide mood swings. In the dormitory, she was troublesome, un-co-operative, and demanding. As her anxieties became intensified, her guilt feelings came into play. She became protective of her mother, whom she had previously accused of forcing her into acts of prostitution. Alice began to complain that everyone at Children's Center was conspiring to keep them apart. This was the same mother who had sent her out begging and had punished her for bringing back only 50 cents after a long day, whereas the mother could show Alice the $10 she had made in a single night. Alice continued to verbalize much of her confusion and depression; she spoke of running away from the center, and, on several occasions, even attempted to jump out of windows.

Under psychiatric direction, specific measures, psychotherapeutically focused, were immediately instituted. When the child was severely threatened by her inner feelings, permission was given to "run away" when she felt so impelled. However, she was asked to get adequately and warmly clothed if she did, and to notify her friends. The worker gave her a pass which read: "Alice has permission to run away from Children's Center. We like her very much and would like her to come back and not stay away too long." Alice held on to the pass for several days. Actually, she left the building only once, but did not run away. She walked up and down outside of the worker's window, waving each time she passed.

The worker initiated and carried out a program of consistent conferences with Alice's counselors concerning the meaning of the child's threats to jump out of the window. It was pointed out that Alice was very frightened and desperate and urgently needed a feeling of warmth, closeness, and understanding. Any action of a restrictive nature, i. e., environmental restraints or physical coercion, would intensify the child's feelings of being isolated and reenforce her concept of herself as an outcast. It was agreed that her counselors would stay as close as possible to Alice, using every opportunity to make her feel wanted and loved. All staff members entrusted with the child's care were instructed to respond to Alice's behavior, however threatening it might be, by expressing a personal

attachment, both in attitude and such words as "Alice, you cannot do this to me." The psychiatrist diagnosed Alice's condition as "anxiety hysteria with reactive depression." Various efforts at rehabilitation, including individual treatment, followed. Today, three years later, Alice is able to live in the center without showing any serious signs of maladjustment.

"The Unholy Seven"

The writers used a similar type of therapeutic procedure in working in a dormitory of 18 adolescent girls, where gang formation was in process. A group had formed a club, calling themselves "the Unholy Seven," and had created a series of disturbances, including open defiance of institutional rules, leaving the institution without permission, truanting from school and sometimes physically attacking others. On one occasion, they continued a disturbance in the dormitory far into the night, keeping awake the whole department of 108 girls. The executive director had to be called, and he removed several of the girls temporarily to his office, from which they returned, after half an hour, to their dormitory. There were no further incidents during that night.

Behavior of this type is very threatening to the institution as a social setting, to its morale, its staff, and the children. Reactions to such threats are different on different levels. A child might try to join the gang, or to escape from it by withdrawal or even by running away. The staff might resort to the use of force in order to protect the physical security of their charges, of institutional property, and of themselves. The administrative response would logically be the removal of the overtly rebellious child from an open shelter to a closed and restrictive environment.

The writers' orientation as psychiatrists and social workers made them seek a different approach. This was, first to try to understand and then to handle the anxieties and hostilities at the root of the explosive violence concentrated in the leading individuals in the dormitory. They felt that if they could do this, they would be able to handle the situation without outside help.

In a shelter such as this, with its constant and rapidly shifting population, it is not possible to have all the current information desirable about the interrelationships between the different dynamic forces in the group. There was not enough personnel to assign in-

dividual social workers to each of the 18 girls in the dormitory. A single person would have to handle this situation.

The psychiatric social worker had to start "on the spot," that is, join the group, on the scene of activities, right in the dormitory and be accepted by the girls. This accomplished, she could carry out two primary functions: (1) act therapeutically in an emergency, and (2) use her diagnostic abilities to single out, for individual handling, the most disturbed and disturbing children in the group. Some of these children would receive individual psychotherapy; others, too ill to be treated in the center's setting, would be removed.

Through daily conferences with the director of the girls' department, the director of psychiatric social services, the chief psychiatrist, and the executive director, diagnostic, therapeutic, and administrative procedures were instituted, and the worker's actions were directed. The executive director, a social worker by training, who had originated the psychiatric program at Children's Center in 1948, co-ordinated the planning.

The worker's first step was to join the girls in the dormitory as a member, casual but interested, not reacting to the apprehension manifested by the announcement of, "There she comes." Without prompting, some of the girls came to the worker. Two spoke excitedly of decorations they were making for the dormitory, and a very casual conversation developed. During this first contact of nearly one hour, the actual disturbance was not mentioned in any way either by the worker or the children.

Because of limitations of time and space, the complete content of the ensuing sessions with the group cannot be presented here. The sessions were held daily, and a great amount of meaningful conflict material came to the surface.

It was during the third session that several of the girls began to test the worker, revealing curiosity which they were increasingly unable to hide. At this point, the worker was able to identify the two leaders of the gang, who could not permit the other girls to establish new relationships without interfering. They revealed themselves by this reaction.

One of these leaders was Carole, aged 15 and one-half. She was a child born out of wedlock, rejected by her family, who had spent her early childhood in foster homes and in an institutional setting for children of Father Divine's followers. When Carole rebelled

against conditions there and ran away, she was placed at Children's Center, at her mother's request. Her adjustment was poor; she was defiant toward counselors and authority, "bullied" other children, and used abusive and profane language habitually. Intelligent and attractive, seemingly fearless of adult authority, Carole quickly became protector and leader for the other girls. It is significant that a number of these girls referred to her as "mother." The psychiatrist diagnosed her condition as "conduct disorder in a child with early character disturbance." She later was removed from the institution.

Carole's staunch ally in leadership was Ann, 14 and one-half, who, with a younger sister, had come to Children's Center following their parents' desertion. These parents were alcoholic and irresponsible; both had many extramarital affairs, often bringing their companions into the home. For a short time, Ann and her sister lived with friends. However, an investigation by the court disclosed this home to be unsuitable, and the girls were placed at Children's Center as neglected children. Under individual therapy, Ann showed regressive tendencies. She called herself "the baby" and expressed her desire to be bottle-fed. Her condition was diagnosed as: "Chronic anxiety state in an infantile personality."

After a few days of contact with the group, the worker was able to establish sufficiently close relationship to Carole and Ann to begin individual therapy, directed toward relieving inner tensions as well as fear of punishment for their actions.

While under treatment, these girls rapidly lost their dominating positions in the group. Whereas they had been aggressive, controlling and coercive mother figures, the worker now replaced them, functioning as an understanding, empathetic, and permissive mother to the group. This change is best illustrated by the following example from one of the later group sessions:

Part of the group's defiant attitude had been expressed by smoking without permission. The worker did not interfere when several girls of 12 and 13 started smoking in her presence. The girls commented that their parents would be shocked if they knew that their daughters smoked. The worker interpreted their attitude: They expected adequate parents to prohibit their young daughters from smoking, and they now identified the rules of the institution as manifestations of good parental care—the same rules which previously they had defied so violently. The girls accepted this inter-

pretation, and their behavior became increasingly conforming in this as well as in other areas.

The disappearance of the group rebellion unveiled and made obvious the disturbances of the individual group members with which the writers dealt separately. They were successful in converting what appeared to be severe and unmanageable resistance by a cohesive group into individual difficulties of a number of homeless, rejected, and disturbed children, each of whom needed individual care and attention, a task for which the writers were prepared and which they could undertake.

Discussion

The therapeutic approach herein set forth as "on-the-spot" psychotherapy by the psychiatric social worker under the direction of the psychiatrist is not intended to cure the patient of psychoneurotic or psychotic illness. It does not always prevent the administrative removal of a disturbed child at a later period. It is focused on the emergency situation which needs immediate attention. In the writers' cases, specifically, the conflict between the patient and his environment (running away, open defiance, etc.) or the conflict within the individual (attempt at suicide), the situation does not permit the loss of even a minimum amount of time to prevent irreparable damage, and the very nature of the emergency leaves very little choice. The generally accepted conditions for planned psychotherapy, namely the readiness of a patient to enter a therapeutic relationship, do not obtain and therefore the choice is limited to either authoritative, disciplinary, restraining, and punitive interference, or the anaclitic type of therapy which this paper attempts to describe.

The writers are aware that similar practices are used by many in and outside of institutions, but little emphasis has been placed on this approach as a specific branch of psychotherapy which can be standardized and can be taught. The use of understanding and support to replace restrictive and punitive procedures is usually considered to be a type of environmental management, belonging to the fields of administration and education, rather than the realms of psychotherapy.

The writers conceive of the anti-social acts against others or against one's self, as described in this report, as the manifestations of acute anxiety, a state of panic in which the ego of the individual

is unable to contain itself because of unbearable inner pressures and, therefore, acts out. The writers consider their approach to be a specific method of psychotherapy, in which the ego of the therapist joins the ego of the patient at the patient's level, with no demands being made from the seemingly elevated position of the therapist as a parental figure. This means, of course, that many children whose diagnoses are frequently formulated as primary behavior disorder, conduct disorder, or delinquent behavior, are considered by the writers to belong to the group of neuroses of the type which Freud designated as "actual neurosis."

This type of disorder is frequently observed in institutionalized children who are away from their families for long periods, without any clear prospects of being reunited, children who have never had the security of a stable home or well-adjusted parents from whom they could learn how to manage even a moderate amount of anxiety. While the illustrations are chosen from many instances, we are still at the beginning and far from the complete integration of this approach into the total life of the institution.

Difficulties are encountered in applying this method for the following principal reasons. First, the traditional restrictive and disciplinary responses to acting-out behavior are deeply rooted in every one of us because they have been an important part of our basic childhood experiences. Second, adequate academic training is not sufficient for acceptance of the anaclitic method in the face of aggression and physical threat. Good will and intellectualization do not suffice when one's own defenses are threatened. Staff members are not in the limited and safe setting of an office, but in the midst of a dormitory filled with excited and disturbed children whose primitive drives have never experienced adequate social controls. Dynamic understanding, plus the high frustration tolerance of a secure person are necessary to practise psychotherapy "on the spot."

Despite the difficulties, the writers have been able to see gratifying results when this type of approach was applied in a systematic fashion. The nursery reported the case of a five-and-one-half-year-old boy, Johnny J., who was running away continually and was unmanageable because he could never be kept with his group. This child, like the others, came from a thoroughly disorganized home. He had a psychotic mother and seafaring father. In the first encounter with the therapist, it was impossible to keep the child in

the playroom, or to develop any situation which would permit the traditional relationship between therapist and child. No force was used to prevent Johnny from running away. He ran into the street, followed by the therapist. (In many instances the therapist has to be able to work under bizarre and socially unusual conditions.) It was then found that the child was very eager not to lose contact with the therapist. The little boy looked back continually to assure himself that the adult had not given up. Several such episodes made it very obvious that the child needed this kind of experience, that is, the security of knowing that the parent substitute would not abandon him, even under the most trying circumstances. After five weeks of therapy, Johnny was able to relate sufficiently to continue in the type of psychoanalytic therapy which is in common usage in child guidance clinics.

These therapeutic experiences are continuously used in the in-service training programs of the institutional staff. This teaching device for counselors, nurses, recreational workers, and teachers serves to establish an awareness of the purpose of psychotherapy; and, after the initial phases of orientation, it contributes to the staff's emotional securtiy. In this way, the atmosphere needed for the practice of ego-supportive psychotherapy is created.

SUMMARY

An anaclitic type of psychotherapy practised in institutional emergencies, arising with individuals and groups in the New York City Children's Center is described. Instead of being subjected to restrictive and disciplinary measures, children of all age groups and of both sexes are treated "on the spot" by an ego-supportive method that tries to reach the child at the level of the acute anxiety and panic which are considered the dynamic basis for anti-social acts, such as physical attack, destructiveness, running away and attempts at self-destruction.

The integration of this approach into the setting and functioning of a large institution and the problems encountered, because of the emotional attitudes of a traditionally-educated staff, are discussed.

Children's Center
Bureau of Child Welfare
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New York, N. Y.

EDITORIAL COMMENT

AS ANYONE CAN PLAINLY SEE

It seems probable that Adam and Eve, weeping over murdered Abel, asked themselves among other things whether Cain was predestined to murder, or whether he had had a choice between good and evil and had chosen wickedness. And the question of predetermination or human freedom of choice has plagued man ever since—although that man can choose is something anyone can plainly see. Or can he?

This journal is minded to discourse on this topic by Lawson G. Lowrey's paper on the subject, "Psychic Determinism and Responsibility," in the October 1953 issue of THE PSYCHIATRIC QUARTERLY. Dr. Lowrey conceives that both psychic determinism and free will exist; he outlines a suppositious boundary and gives a persuasive example to illustrate his point of distinction; those interested in a fellow-scientist's lucid exposition of his views on a point that has exercised philosophers and theologians alike for centuries are hereby referred to that excellent article.

The point of chief concern in this present discussion is less the existence, nonexistence or co-existence of psychic predeterminism and free will than the day-to-day assumptions we all must make on the subject—although on the matter of free will's existence itself, one might well hazard at least a feeble speculation. To begin with, it could be observed—without prejudice to anybody who might feel this is treating the subject lightly—that there is a great deal of virtue in many of the things that anyone can plainly see. To take the simplest possible instance, anyone can plainly see that the sun rises and sets, whereas we all know it doesn't; but it simplifies life and language and serves numerous other useful purposes to act and speak in the ordinary affairs of life as if it did.

So anyone can also plainly see that man possesses free will; that he has freedom to choose; that he can say or not say, do or not do, as he pleases—all within the limits, of course, of generally recognized human capacities or incapacities, and all, of course, within the scope of matters manipulable by the individual. But what anyone here can plainly see is a phenomenon that contradicts much scientific data. (To what extent these data are applicable here, is

a question to be discussed later.) And yet, in contradiction to scientific data or no, the freedom of will which anybody can plainly see is quite possibly at least as useful a concept as the view (contrary to fact as it manifestly is) that the sun rises and sets.

In the whole of the western world, if not in the whole of the earth, we frame our social, religious, political, familial and interpersonal relationships on theories which assume the existence of individual freedom of the will. We punish children for misdeeds and criminals for crime, on the theory that they *willed* (chose to perform) their acts and that punishment may deter repetition by themselves and others. Of course the theory of punishment is not that simple, and the example is perhaps one of our less successful applications of the conviction that there is free will—for there is more and more acceptance of the scientific idea that the criminal, in many cases at least, is a person of limited responsibility. But society has so far not devised a more workable or more generally satisfactory substitute for the assumption that an ill-doer *chooses* of his own will to perform his ill deeds, and so should suffer for them.

In civil law, the concept of responsibility is rigid. A mentally normal adult is held strictly accountable for his business agreements. Most testamentary contests turn on the ability of the testator to exercise what is regarded as his normal mental faculty to *choose* how he will have his property distributed after death. The man who signs a contract or the man who signs a will (a significant word in itself) is not considered, under our system of law, to be operating on predetermined lines.

We assume, in our ordinary conduct of affairs, that the same mechanism is operating—that we have free choice (within ordinary limits imposed by price and marketing conditions) between pork chops and shad roe for dinner, or between going to bed with a book or staying up and watching wrestling on television. We may hold philosophic beliefs, or think there is scientific evidence, to the contrary; but we act from day to day and moment to moment as if we recognized in ourselves and other normal individuals the power of choice.

We "choose" (subject to many recognized and many more unrecognized or unconscious factors) our occupations, our avocations, our vacation spots, and our marital partners. Only in this last case, is there a partial, curious, generally-recognized excep-

tion. The poets, song writers and many of the immediate participants in romantic love frequently pay awed respects to the fate—or predetermination—that brings two particular lovers out of a whole world together. But one can also measure the depth of this belief by the self-reproaches one hears after an unhappy love affair or an unfortunate marriage. They are invariably: "Why was I so fooled? What on earth did I ever see in . . .? How could anybody be such an utter idiot?" Even here, it is before the happy fact that one sees the hand of destiny; after the unpleasant eventuality, it is easy to see only human stupidity by humans who ought to have known better and certainly were free to do better. And the vast majority of psychiatrists—theories to the contrary notwithstanding—disagree in practice with any ideas that Fate predestines love affairs or arranges marriages.

As far as is generally known, these observations hold true even for the peculiar society that exists behind the iron curtain. It is true that the free will of the bourgeois and such cattle suffers from economic determinism; but our world has never heard of a kulak's crimes being forgiven on the grounds that he couldn't help them; and that the honored and the mighty, who are *free* to pursue the Marxist way, frequently *choose* foul collaboration and horrid treason with the wicked capitalist instead, is well publicized to the free world every time a purge trial is held to signalize a former leader's fall. Strange to us as their stnadards of judging its results seem, the belief in freedom of the will is evidently held in somethink like orthodox western fashion in the people's democracies.

In religion, if any sect in the western world believes all man's acts are preordained, its numbers are inconsiderable. Outside the Western World, the Moslem faith is based on the tenet that all the world's affairs and all human acts are determined by inexorable fate! But the Moslem, in practice, is a "reasonable" fellow; he assumes in practice that man can choose good or evil and punishes him relentlessly for choosing evil.

Among the Christian groups, predestination, which is much like but not quite the same thing, is probably the nearest one can come to religious belief in predetermination. The belief that man is free to choose between good and evil is a fundamental tenet of most of the sects which are in the Judaeo-Christian tradition. And even predestination is now a question for the thelogians rather than a

conviction profoundly affecting daily life. Believe in it or not, nobody acts in common affairs as if we were all predestined.

This review of what anyone can plainly see is presented here because we scientists act just like everybody else where the question of freedom of the will is concerned—as anyone can also plainly see. And we in the psychiatric field act much like every other scientist when questions of freedom of will arise. In fact the assumption that man has a free will may be more fundamental to the practice (not the theory) of psychiatry than to any other science. Psychiatry is a science of the mind; will (or whatever predetermined mental or emotional reaction performs what we usually call acts of will) is a part or attribute of the mind. It is a part or attribute that is strongly affected in various psychiatric conditions, is impaired seriously in organic states and in drug and alcohol addiction, and is made use of effectively in virtually all types of psychotherapy.

There used to be a great deal more talk about the will in professional circles than there is today. The psychotherapist, like the theologian, spoke of strong and weak wills. The psychiatrist of "pre-dynamic" days laid stress, and set great store, on exhortations and routines designed to "strengthen the will." Professional interest overflowed into streams of powerful if turgid popular writing. Books on the power of the will and on strengthening the will became as popular as the how-to-be-happy-though-human type and its offspring have been in the last 20 years. The hero of popular fiction changed his garb; he frequently lost classic beauty and some of his old too-lofty moral stature; but he strode through historical novel and romance alike, clothed in the shining garment of his will power. Such a concept of the hero, is, of course, as old as man; Prometheus is the ancient symbol of will unbroken by divine wrath; and it certainly is not by accident that Milton's Lucifer (also the bringer of light) boasts of his "unconquerable will."

But heroes slumber; prototypes in fashion, fiction and science change; the well-bred, handsome, intelligent, athletic, financially successful hero who never had a moral mishap and never made a stupid mistake was the general social and fictional ideal in the early years of this century. Then what must have been profound philosophical, psychological and sociological changes freed Prometheus from his chains and made the man of will the goal of human striving once more. It was then that Winston Churchill

(the American novelist, not Sir Winston) framed his historical fiction around such figures as Abraham Lincoln, John Paul Jones and George Rogers Clark, whom he conceived as leaders through the almost superhuman power of their wills; and that Ethel M. Dell created her romantic fantasies, with heroes whom one would have been well advised to avoid on any moonless night, but who were overpoweringly attractive to women through possession of the way of the eagle—the chilled steel might of the will.

With the gradual increase in prestige, both in the theory and the practice of dynamic psychiatry, there has been much less emphasis —another matter which anyone can plainly see—on the will. Dynamic psychiatry is the result of the discovery and early exploration of a vast and previously unknown territory that has proved to make up by far the greater part of man's mind. It is the tremendous new-found world of the unconscious—about which we may know now approximately as much as Balboa did about the new world he saw when he gazed into the far Pacific from his peak in Darien. But what we have learned from our early explorations reveals a savage and storm-swept waste in which, if the will exists, it does not wear the familiar garments by which we recognize it in the conscious affairs of life. What we do recognize is an enormously confused but ceaselessly active progress from cause to effect, from new cause to new effect, of ordinarily unperceived mentation. We see unconscious effect from unconscious cause, conscious effect from unconscious effect—and, in psychopathology, neurotic and psychotic symptoms of florid nature and infinite variety, all traceable as effects of one or another unconscious cause. We now recognize cause and effect in the forgettings, the misplacings, the mistakes, of everyday life. We do not "will" to forget a name, lose a jackknife or break a vegetable dish—we do those things, not because of will (in this case, ill will) but as the cause-and-effect result of unconscious wishes (which have their own causes). An unconscious wish to do something is not precisely the same as a conscious wish, and is certainly not the same as a conscious will to do it—a little matter that creates daily misunderstandings and considerable grief when psychotherapists fail to make the distinction clear to patients.

Psychoanalysis and the other forms of dynamic psychiatry related to it base both their theory and their practice on the tracing of aberrent and evident effect to causes buried in the unconscious.

pliance with the law of cause and effect. There are notable exceptions, as when a patient may seek treatment to avoid arrest or disgrace for perverse activities, but an element of what we are accustomed to call choice generally accompanies entrance into analysis. Some analysts are reluctant to accept unwilling patients; others consider unwillingness to indicate poor prognosis; all anticipate increased resistance if the patient is unwilling. An instance could be cited here where an analyst who has specialized in the treatment of homosexuality considers the patient's desire (wish or will) to become normal an absolute prerequisite to successful treatment.

What the layman would call the will figures in all phases of psychotherapy, psychoanalytic or otherwise. What in ordinary language we call stubbornness, and think of as the "I won't" function of the will, certainly operates in resistance; an apparent will or desire to please (whatever its mechanism or motivation—usually fear) inspires the "false remissions" of symptoms patients sometimes bring forth as "presents" to their analysts; and what we think of as the will very evidently plays a part in insight, though not the major part, as evidenced by the difference between insight and intellectual understanding, which can be achieved in part at least by an effort of "will." Be it emphasized that in referring here to these phenomena as wish, desire or will, there is no implication that the analyst has in mind the same mechanism that the laity see in these processes. Far from it, the analytic concept is no such simple thing; but analyst and layman are referring to the same phenomenon. There are analogies. The Norseman saw and heard Thor hurl his terrible hammer; his more-schooled descendant sees and hears an electrical discharge rip across the sky; what ancient man saw and heard and what modern man sees and hears is lightning. Like lightning, what we commonly call will is an observable and recognizable phenomenon, in whatever terms one explains it.

And however one explains it, we employ the concept of will—and, in psychiatry, we have to employ it so—as if will were the matter of free choice, which anyone can plainly see it is. Without such a concept, all psychotherapy would be difficult, much would be impossible, and all counseling and all psychological guidance would also be impossible. A psychologist would not know how to advise a person who did not feel he had freedom to accept advice; he also would probably *a priori* decide there was something serious the matter with him. As one psychologist remarked in conversa-

tion recently, he would not be surprised by a person's assertion that there was no free will, but he would diagnose subnormal intelligence immediately if the man actually acted as if he believed it.

One need not conclude necessarily from this that what is here depicted is a schizophrenic, schizoid or even distressing state of psychological affairs. What is depicted may—just possibly—instead be the not unknown matter of a gap in our scientific knowledge. We recognize without undue distress a gap between our knowledge of the physical activity of the neuron and the psychological activity of the mind. We recognize—and our best theoreticians are puzzled by—a gap in knowledge which does not permit us to explain subatomic physics in terms of macroscopic physics, or macroscopic physics in terms of subatomic physics. This latter is a gap some of our best scientific minds are trying to bridge by the development of a satisfactory unified field theory. That they have failed so far to develop it is a challenge to human achievement and may be a handicap in human expression of scientific values, but it does not demonstrate a split in scientific mentality, or even a scientific dilemma. While we are trying to close the gap, we can only record the observation that subatomic physics appears to act in one fashion and macroscopic physics in another.

As practising—not theoretical—workers with the mind, it might serve us well if we, like the physicists, recognized a gap in our knowledge, and further recognized that on one side of it, matters (except in the interior of the atom) appear to move inexorably from cause to effect, while on the other side, the human mind appears to exercise a restricted freedom of choice. How such a state of affairs could come about, we do not know; but psychiatrists are just as much and no more obligated to present proof of or explain their observations than are men of other sciences. The Doppler shift in the spectra of moving bodies was noted 112 years ago; even with observations made through the new 200-inch telescope at Palomar, astronomers are still arguing whether the shifts in the spectra of the farthest of the great star-spiral nebulae indicate the explosive recessions they seem to show.

The psychiatrist is in no better, and perhaps is in worse, case to prove his point than is the astronomer. He can follow one or another or ten thousand or a million mental phenomena back from their overt manifestations to their apparent causes with full confidence in the general accuracy of the reconstruction; but he can al-

ways be certain that his reconstruction is very far from complete. He is investigating a situation which, simplified beyond reason, might be represented by a formula like $C^n=E$. Here C would equal a multiplicity of causal factors, the easily traced direct determinants. They are raised to the nth power by the determinants of the direct determinants, these secondary determinants' determinants, their determinants' determinants, and so on to a value certainly approaching plus infinity. E is the final effect, the thought, act or other mental phenomenon under investigation. Absolute proof that only a simple cause-and-effect relationship exists between mental phenomena is plainly out of the question. The astronomer may have an easier task in proving that the Doppler shift toward red from violet indicates the explosion of the universe—and even here there is an alternative explanation which it might seem, to most other scientists, impossible for astronomy ever to dismiss. Leaving aside the philosophical question of what is proof, the assumption that there is only cause and effect in the mind is in the same case with instances in many other sciences when it comes to presenting what is generally accepted as scientific proof of theory.

Of course if one notes the difficulty of scientific proof of cause and effect in human mentation, one should also note that the contrary condition of free will is even more difficult to prove. Except for subatomic physics—and even there most non-physicists probably have a suspicion that there are cause-and- effect relations that are simply not now understood—we see the general operation of cause and effect throughout the world of science. It is difficult, against this background, even to imagine a situation where this relationship does not obtain. Yet the science of the mind (and we maintain firmly that it is a science by all recognized standards) has much more unexplored territory than the gap already cited—where mentation borders somehow on neurological physiochemistry.

We cannot give a complete or satisfactory definition of the human mind, although, scientifically (not necessarily philosophically or theologically), it serves us well to consider the mind from one aspect as a function of human life, and from another as a function of the human nervous system. But we do not know how mind fits into either picture. We have so far been unable to explore, and cannot even guess at a map of, the territory linking mind to the

nervous system or linking it to life. We cannot even observe, and we certainly cannot interpret, its features. Life itself is generally considered a function of the organism. We—again scientifically (not philosophically or theologically)—understand it poorly and can't explain it adequately. We can safely defy anybody to define it.

A reasonably recent edition of *Webster's New International Dictionary* devotes more than a column to what can only be described as a series of unsatisfactory attempts at definition. The first five definitions, all pertaining to the quality which distinguishes animate from inanimate objects, and thus pertaining to the subject of present scientific interest, cover more than 50 lines and attempt to define "life" by naming distinctive attributes of living things—as metabolism, growth, reproduction and the internal process that enables adaptation to environment. Would it be unscientific to suggest that we might possibly add to these other processes, which we understand poorly or not at all, a possible process by which living things can exercise limited choice between alternatives? We can, for instance, observe metabolism, growth and reproduction. We know something, but very far from all—from careful scientific observation—about what goes on in these processes; but we cannot explain (scientifically) how or why they started or why they continue. We swallow a good many camels in the shape of tremendous breaches in both observation and understanding; a gnat or two more might not impose too much strain upon us. Is a choice-making faculty totally outside the possibilities of nature (even if outside general physical law as we now understand it)?

There are some rather interesting questions here. Once the existence of a choice-making faculty as an attribute of life is assumed, it seems reasonable to assume that, like other attributes of life, it could develop as the life form itself develops, perhaps culminating in what appears to be the wide ability to choose which has been called (however wrongly) free will in man. If there is anything to the idea at all, there could be a vast field for exploration here. If a man can choose and is not a machine, it seems obvious that—each within his lesser limits—so can a dog, a cat or a horse. But can a snake or a fish? Is even an amoeba only an animated machine, subject to one tropism after another? Or in some dim way beyond present human comprehension or the possibility of comprehension, can it choose whether to extend this or that pseudopod?

All this is not put forth as a theory or a hypothesis or even a supposition. It is merely a matter advanced to suggest that here —as in subatomic physics, as in extrasensory perception, and maybe in the red shift that puzzles the astrophysicists—there are things not to be explained by our current understanding of the general laws of physical nature. Such things would be neither supernatural nor abnormal; they would simply be things we do not understand as yet, but the existence of which we accept on the basis of convincing evidence.

Again noting that only the scientific aspect is under discussion, it should again be emphasized that freedom of choice, or free will, or whatever one cares to call it, is a tenet of most of the religions of the western world. It is a theory supported by a respectable representation of occidental philosophy. Furthermore, it is one of those things which (like the fact that the sun rises and sets) has been established these many tens of thousands of years by ordinary human experience and observation. That people possess free will, is, as has also been emphasized here, an indispensable assumption in psychiatry.

A man—as anyone can plainly see—is a creature who, within the limits imposed by heredity and environment, is free to do as he pleases. The question in this instance is whether (unlike the matters of sunrise and sunset) what anyone can plainly see is in conflict with sound scientific thinking. It is important to psychiatry because—whether it is true or untrue—we are compelled to act as if there were truth in it. What is suggested here is that—with scientific knowledge in its present state—we do not have the incontrovertible facts, as sometimes supposed, to establish that there is no truth in it. And we may never have such facts. We wonder if, under these circumstances, we might not all do well to do as we do with many other practices that are justified empirically. That is, we might lay less stress on the controversial nature of the subject, place a little more stress on the fact that there is generally something (besides philosophical bias) to be said in favor of the probable validity of a concept or an instrument which works, and to urge more inquiry and less closure of mind on the matter.

It seems possible, and other questions than this matter of free will so indicate, that science is too hasty to apply to the mind principles which are valid in such fields as chemistry, gravitation, op-

tics and mechanics. Where such a vastly different phenomenon is involved, a little less haste might lead eventually a little nearer to the truth. It is not impossible that in the case of free will, what anyone can plainly see may be closer to the actuality than conclusions based on the application of principles from the purely physical scientific disciplines.

BOOK REVIEWS

On the Social Frontier of Medicine. By IDA M. CANNON. 273 pages including index. Cloth. Harvard University Press. Cambridge. 1952. Price $4.75.

In popular, concise and inspiring description Miss Cannon leads us from the first faint efforts to establish—as a profession—medical social service in hospitals to the diversified and specialized medical social service of today. It is hard to realize that so established a profession in our daily lives should only be about 50 years old. Miss Cannon did pioneering work with the help of Dr. Richard Clark Cabot of Massachusetts General Hospital in Boston, which became the cradle of medical social service in 1905. Bellevue Hospital in New York City followed a year later.

Trained as a nurse, the author started her professional life as a "visitor" among the poor. The first faint beginnings of social service in Boston were limited to the out-patient department (clinics); and it took time and efforts to "sell" medical social service to hospital administrators. Up to that point the medical social workers were treated as intruders in the hospital when they tried to follow up their patients in the wards. But slowly Miss Cannon's fighting spirit and enthusiasm resulted in establishing a profession that has become so important that we can barely visualize hospitals without a social service division which acts as a liaison between the doctor on one hand and the patient and his family on the other.

Dr. James J. Putnam, especially interested in psychoneurotic patients, was the first to introduce the forerunner of present-day psychiatric social work into the hospital set-up. It was he who invited Freud to come to Boston to lecture, a venture which met with great doubts and disapproval on the part of the medical profession.

Miss Cannon's book not only gives us the full development of medical social service but in conjunction with establishing this new profession, she leads us into industrial legislation, abolition of sweat shops, public hygiene for workers and change of attitudes on the part of the public. It is hard to realize today that at the turn of the century a female patient affected with lues was not admitted to a hospital "because she was immoral and her sickness was her own fault," while selected male patients could and did seek treatment and cure of the disease, discussion of which was taboo until 1934 when Dr. Thomas Parran, commissioner of public health of New York State was forbidden to broadcast a lecture on "Doctors, Dollars and Disease"—which was part of a series for radio under the sponsorship of the National Advisory Council on Radio in Education of the Columbia Broadcasting System—because he would have mentioned the word "syphilis" over the

air waves. He promptly resigned from the advisory council. In July 1936 an article "Why Don't We Stamp Out Syphilis" by Dr. Parran was printed in the *Readers Digest*. Barely 20 years have gone by, and today we are reaping the results of the valiant efforts of medical men—and of social workers like Miss Cannon. Her book should be read—and not only by professional medical social workers; it is also of value to the physician.

Limbo. By BERNARD WOLFE. 438 pages. Cloth. Random House. New York. 1952. Price $3.50.

Limbo is a somewhat appalling satire on man's psychic masochism and capacities for self-damage. The author notes that he is indebted to Groddeck, Theodor Reik, and Bergler for his conceptions—the greater part of the indebtedness being to Bergler.

This is a full-length, bitter satire which reaches both the temper and the stature of Swift. Few psychiatrists will find any reason to be happy about it and it will enrage some of the psychosurgeons. Wolfe's writing is brilliant; his understanding of personality is profound and his picture of world-surrender to humanity's basic neurosis is frightening. The reader gets the most unpleasant feeling that something like this could happen. This reviewer believes this book to be one which nobody interested in dynamic psychology should fail to read.

The Conception of Disease, Its History, Its Versions and Its Nature. By WALTER RIESE, M. D. 120 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

As the subtitle suggests, this book takes up the subject of disease from a broad, historical and philosophical point of view. It is no simple treatise, but a complex and penetrating analysis. As the author states:

"Though disease is a basic experience of human existence, each stage of civilization has its own concept of disease. But, it would not be possible to write the history of the various concepts of disease as the unbroken line of a chapter of human thought leading in the irreversible march of time from the most primitive and crudest magic thought to the most refined and elaborate concept of modern psychology. In fact, the various concepts of disease have always been overlapping, living side by side at each stage of human history, and the road from primitive to rational thought has to be sought and rediscovered anew by each generation and each individual."

This is a small but scholarly work which has much to say. The author traces concepts of the origins of disease from anthropological, moral, physiological, anatomical, psychological and biographical points of view. The concepts of outstanding figures in the fields of philosophy, medicine, and literature are discussed.

Treatment of Mental Disorder. By LEO ALEXANDER, M. D. xi and 507 pages. Cloth. Saunders. Philadelphia. 1953. Price $10.00.

The author stresses in his treatment methods the correlation between the psychodynamics of the treatment problem and the "scientific principles of neurophysiology." Psychotherapy in psychotics is regarded as an adjunct to physical treatment, with its chief value in improving the adjustment of that percentage of patients who are benefited by treatment, rather than in increasing the number of those benefited. As far as what "school" of psychotherapy is used, it is rather difficult to pin the author down, as he quotes extensively from many sources—what emphasis there is turns upon the work of Frieda Fromm-Reichmann.

Throughout Dr. Alexander shows a commendable interest in tracing exact cause and effect relationships, rather than in accepting an "it works but we don't know why" attitude. While workers in the fields allied to medicine could undoubtedly derive benefit from sections of this book, the emphasis upon neurology will limit its general usefulness to members of the medical profession.

They Learn What They Live: Prejudice in Young Children. By HELEN G. TRAGER and MARIAN RADKE YARROW. 392 pages. Cloth. Harper. New York. 1952. Price $4.50.

This is a report of a three-year project, carried out in Philadelphia public schools, for the study of racial and religious prejudice and stereotype concepts among school children, and their correction by real experiences in intercultural living. It necessarily deals with the problems of prejudice in teachers and parents. It finds a need for the school to teach democratic values which parents cannot be relied upon to teach. An illuminating contrast is made between two hypothetical teachers who both believe in "democracy," one in a static utopia, the other in dynamic social growth. Curriculum changes must be supported by teachers who have adequate "know-why." Although adequate statistical measure in a project of this kind is impossible, convincing evidence is presented that the social thinking of very young children can be constructively influenced. To the thoughtful reader, as well as to the authors, this study raises more questions than it answers.

The verbatim and anecdotal material is abundant and is easily read. The description of experimental detail will be useful to subsequent researchers in spite of methodological flaws, but it will discourage the casual reader. A "popular" presentation of this material to appeal to the grade teacher and the trainee would be very desirable. The ubiquity of prejurageous people in each school community.
dice will leave the real progress in this work to the efforts of a few cou-

The Best Years of Your Life. By MARIE BEYNON RAY. 300 pages. Cloth. Little, Brown. Boston. 1952. Price $3.75.

The author points out that since the beginning of the century, our life expectancy has been increased 20 years. She suggests that we not waste this time but use it to do the things we have always wanted to do. Her main point is that at 60 we are as fully capable as ever—if not more so—of leading very active, useful lives.

Although the reviewer agrees that one can still lead a useful life, and continue to learn and also to make contributions to society at an advanced age, there are many conclusions the author arrives at that are unwarranted and contrary to fact. These are included in the first 80 to 100 pages of her book and, therefore, are trying to wade through.

She asserts that it is "perfectly normal that a man of 77 should be elected to one of the most strenuous jobs in the world." The author implies that it is the rule today for people of 75 and over to be very active. Although all of us would like to see it so, this is not true. In addition, the author implies, too, that because we live longer our youth has been lengthened, that a man or woman of 60 today is the man or woman of 40 one hundred years ago. While it is true that our life span is probably 20 years longer than the person living in the middle or late nineteenth century, it is ridiculous to assume that youth has been extended by the same measure. This is to ignore what we know of the physiological processes of the body. The author, too, hints that exercise by people over 80 makes them strong, healthy, and vigorous. It seems more logical that the converse is true: People who are healthy, strong, and vigorous (at 80) will exercise.

There are other misunderstandings and misinterpretations, medical and psychological. But if one is able to read the first four chapters with appropriate reservations, he comes upon entertaining and informative material. The author goes into detail about the various hobbies that can be enjoyed by the older person and gives rather complete data as to community resources or as to where one can obtain information. The author's style of writing is enjoyable, with a liberal sprinkling of humor and anecdotes.

Satan in the Suburbs and Other Stories. By BERTRAND RUSSELL. 148 pages. Cloth. Simon and Schuster. New York. 1951. Price $3.00.

Bertrand Russell disclaims purpose, beyond the pleasure of writing, in this series of short stories. Perhaps it is idle to seek purpose beyond the pleasure of reading; but the title story is a study in psychopathology; and the "Infra-redioscope" is a little masterpiece of science fiction involving the psychology of public relations and equipped with a most astonishing ending. Lord Russell is a master of lucid twentieth century prose. He has written these little piece, however, in a mannered, Victorian style which recalls Dr. Watson (of Baker Street). This is, of course, deliberate and is delightful.

The Serpent and the Satellite. By F. Alfred Morin. 465 pages including index. Cloth. Philosophical Library. New York. 1953. Price $4.75.

It took a psychiatrist to send a long-haired comet careening fabulously around the skies, stopping the earth in its rotation and finally winding up as the planet Venus. The publishers do not give the professional background of F. Alfred Morin whose book is described as "an inquiry into the probable source of man's orthodox dreams of the spiritual principle." Mr. Morin conceives that the religion of the mountain and the serpent originated from a period when the core of the molten earth was hardening. The core split, part of it attracted by gravitation to the scum that was forming continents. This outer portion, or the mobile core, traversed the earth, serpent-wise, again and again, creating land outlines and mountain ranges, and thus giving rise to the legend of the earth serpent, for man or proto-man, Morin thinks, lived in those days. As the hardening process put an end to this serpentine boring, the mobile core emerged as a tremendous mountain, giving rise to the religious symbol of the mountain.

Repelled by an electrical charge of the same sign as the earth's permanent core, the mountain flew off and became the moon. This cataclysm gave rise to floods, to tidal waves, to vast volcanic activity which obscured the atmosphere and ushered in the Ice Age, and—by radiation-caused mutation—made human man from dwarf predecessors. The author traces the mountain and serpent religious signs and legends of mankind to these happenings, the occurrence of which we can leave safely to the physicists, astronomers and geologists. These symbols are commonly considered to be phallic; and this seems, up to now, to have been a perfectly satisfactory explanation.

Nijinsky. Paul Magriel, editor. 80 pages. Cloth. Holt. New York. Second Printing, 1947. Price $3.00.

Paul Magriel, editor of *Dance Index*, has thrown together a series of essays on Vaslav Nijinsky as a sort of appreciation of the immortal dancer. "Thrown together" is used advisedly because Mr. Magriel in his haste never explains why he chose these essays, nor does he bother to intertwine these into a coherent account of the great artist's career which culminated in psychosis and confinement in a Swiss institution. Had this reviewer not read the famous biography of Nijinsky by his wife, he would have been floundering at sea on the basis of a first reading of this book. It is, therefore, not to be taken as an introduction to Nijinsky and his art, but rather as supplementary material. The book, however, presents for the first time a number of hitherto unpublished photographs of Nijinsky in his favorite roles. Also interesting are two drawings made by Nijinsky after the onset of his illness. There is a rather sketchy description of these and an attempt at analysis. It is pitifully short and vague.

The Scattered Seed. By STUART ENGSTRAND. 248 pages. Cloth. Messner. New York. 1953. Price $3.00.

"Mr. Engstrand," the dust cover says, "is concerned chiefly with behavior patterns which depart from what is conventionally known as normal. . . . He has succeeded in making the 'psychological' novel peculiarly his own form of literary expression. . . . Some reviewers and psychological experts have found his characters and their situations drawn with such expert and deadly accuracy, that they have believed, erroneously, that Mr. Engstrand took psychiatric counsel on them."

This reviewer remembers that three of Engstrand's previous books, *The Sling and the Arrow, Beyond the Forest,* and *A Husband in the House,* were reviewed in THE PSYCHIATRIC QUARTERLY. Their contents were described as the most fantastic misuse and misunderstanding of the psychiatric A. B. C.'s. As far as "psychiatric counsel" is concerned, the revealing blurb of *The Sling and the Arrow* stated precisely where Mr. Engstrand's psychiatric wisdom came from: Stekel's outdated books.

In this recent addition to his fast-growing encyclopedia of misunderstandings, Mr. Engstrand has this to say about the central idea of his book: "It's the build-up that counts. And now it was happening: the build-up. Everything in life would turn on her. Each move, each glance she made would take on increasing importance. It was not love, it was not wanting to get married. It was what makes good men leave their wives and kids for some dame. They build up something about the dame, something that's not real. Though it's real enough in their own minds. Some guys embezzle. Some kill. Just for the dame. And it's not really the dame. It's just that building up something inside themselves. Not that they want to do it. It gets bigger, feeds on itself, until something breaks. Sometimes it's a heart. Sometimes a skull. The build-up gets bigger than a guy. And then it blows up in his face. . . ."

This "theory" presented as brand new, is only 130 years old; it can be read, expressed in cultured language, in Stendhal's *L'Amour.* To refresh Mr. Engstrand's memory:

"In love only one's own illusion is enjoyed. . . . At the salt mines in Salzburg, a branch stripped of its leaves by winter is thrown into the abandoned depth of the mine. Taken out two or three months later, it is covered with brilliant crystals. . . . These souls burning too vehemently or too suddenly fall in love on credit. . . . Before there is a possibility of becoming impressed with the true nature of things, they envelop them—from afar and before they are even visible—in that imaginary charm which springs inexhaustibly from them. Then they approach and see things not as they are but as they themselves have made them. . . ."

Bringing down the famous theory of "crystalization" to his own "build-up" level, trusting that his readers are neither familiar with Stendhal, nor

the present psychoanalytic theories on romantic love, connecting Stendhal's intuitive notions with the function of the super-ego, Mr. Engstrand makes his "case." Of course, his superiority is clearly proved: Stendhal's book on love sold, in the first 11 years after publication, exactly 17 copies, whereas Mr. Engstrand's books sold in half the time—more than 3,000,000 copies, as the blurb of this latest proudly announces.

The Scattered Seed describes a drifter, temporarily working as tree-trimmer, who gives a "build-up" to two women, both of whom disappoint him. Having but one idea at his disposal—that of "build-up"—the author overlooks all the psychopathic and masochistic trends in his hero's character; he is completely impervious to the fact that idealization of a woman does not include stealing for her, as the hero of the novel actually does. Having committed that error, a few other A. B. C. mistakes are added: A neurotic symptom is inanely explained, the function of the inner conscience misrepresented, etc. This "psychological" novelist reveals himself once more as psychological misinterpreter. The type of writing is best characterized by a sarcastic remark John Galsworthy once made: "For a man who can't see an inch into human nature, give me a psychological novelist." Even Galsworthy could not have foreseen that the grotesque misrepresentation of both homosexuality and schizophrenia contained in *The Sling and the Arrow,* "is now required reading in a number of college psychology classes" (verbatim quotation from the present novel's dust cover).

The only reason for devoting so much space (or any space at all, for that matter) to Engstrand's nonentity of a novel, is simply the fact that the so prevalent misrepresentation of psychiatry by some novelists should, from time to time, be met with protest. And Engstrand is one of the worst offenders.

Some Rights of Children and Youth. By PHILANDER PRIESTLY CLAXTON. 82 pages. Cloth. Exposition Press. New York. 1953. Price $2.50.

Children's rights are recognized in our society by legislation aimed at restricting the occupations, hours and ages at which they may work. Statutes guarantee their educational rights. Laws protect them in their property rights, relations to guardians and foster parents. This book is the first publication, to this reviewer's knowledge, to take up the entire gamut of moral, ethical, cultural and economic rights which children and youth should enjoy. The author draws from experiences as teacher and school and college administrator to list a series of rights, explain them and suggest how they may be attained. Some are on such a high ethical plane that one may wonder how they can be reached in a society so imperfect as ours. Nevertheless, this book should have the widest publicity. It is commended for the attention of parent-teacher and other organizations concerned with children and youth.

Relax and Live. By JOSEPH A. KENNEDY. 205 pages. Cloth. Prentice-Hall. New York. 1953. Price $3.95.

The bookshelves are crowded with "routine" monotonous books on how to live a happy healthful life. *Relax and Live* is not in that category. It is a lively book containing much that any reader will want to apply. The author, a director of physical education, believes, and convincingly shows, that most persons lead tense and strenuous lives and have forgotten how to relax; and that all persons could do a better job of living if they knew how and when to relax.

"Wasted energy, and the fatigue resulting from tension, do more damage than just making us feel tired and worn out. They impair our skill. . . . Relaxation is not something you do; it is something you don't do. Doing requires effort, and effort makes tension. You relax when you stop doing, when you stop making efforts. . . ."

The author specifically describes his method of suggestion for producing relaxation; he gives advice as to methods of relieving insomnia, of using relaxation while a person works, of altering annoying habits and adjusting to tension in family or social life. Teaching patients to relax is just as important in medicine or surgery as it is in psychiatry. Relaxation therapy should be studied and applied by all doctors, and this book will help the doctor to understand its importance.

An Approach to Measuring Results in Social Work. By DAVID G. FRENCH. 178 pages. Cloth. Columbia University Press. New York. 1952. Price $3.00.

Although this book was written to report on an evaluative study of certain social work services in Michigan, it is perhaps most effective as an evaluation of social welfare research today.

The original plan of the study reported upon is presented, along with a history of the shrinkage caused by unrealistic formulation of the questions asked and the consequent limitations. The attempt to ask questions to which answers could be found with the money and staff available forced a consideration of scientific method in social science research. The author has obviously been mulling over these questions for a long time.

He concludes that evaluative research in social welfare can only be effective to the degree that social work research is continuous, unified and oriented from a consciously stated theoretical foundation. For this reason he achieves an excellent argument for established research units in schools of social work and for their support by staff and community. With this statement, social welfare research also makes definite approach to social science theory and attempts to absorb the methods and lessons painfully learned by its brethren.

The Michigan project was, however, forced to turn from an evaluative project of services to an evaluation of previous evaluative researches. In this, the greatest shortcoming scientifically rests in failure to review and analyze all such previous efforts. Rather, the author has chosen to analyze four recent studies, which are presented as an appendix. The effect of this is to make the book an outline of the thinking and activity necessary for a project in measuring results of social work—with four illustrative studies. One can hardly agree with the author that these are "representative" studies for they fail to include much that has been done in other social sciences.

In bringing forward the idea of an institute for Social Work Research and emphasizing the close alliance such an institute must maintain with all social science research the author has certainly helped the maturation of social work. One may therefore forgive his succumbing to a few of the very errors of which he would forewarn.

The Uneducated. By ELI GINZBERG and DOUGLAS W. BRAY. xxv and 246 pages. Cloth. Columbia University Press. New York. 1953. Price $4.50.

Despite the emphasis put upon education in our present society, the United States is still a long way from achieving the ideal of universal literacy. While it is true that the majority of the illiterates in the country are a residue of past mistakes, it is estimated that there are about 125,000 children a year who pass the age of compulsory education without the ability to read and write. As might be suspected, the Southeast is the greatest offender in this respect.

This book is part of a project devoted to the conservation of human resources, and is a start on the work of evaluation. The emphasis here is on wartime and occupational adjustments, rather than on the psychological, which is to be the subject of a later study. One complaint this reviewer has concerning this book is the lack of emphasis placed upon the difference between lack of capacity and lack of training—in other respects the endeavor must be applauded.

A Sober Faith. Religion and Alcoholics Anonymous. By G. AIKEN TAYLOR. 108 pages. Cloth. Macmillan. New York. 1953. Price $2.00.

The author, a minister, realizing that he had failed in preaching to the chronic alcoholic, decided that perhaps he did not understand "the Power greater than ourselves" about which Alcoholics Anonymous spoke, and, to satisfy his curiosity, attended A. A. meetings, talked with members and went along with members when they made their calls upon alcoholics who had "slipped." His book is well written and one could predict that it will become another textbook for the chronic alcoholic and for Alcoholics Anonymous.

Dynamic Psychiatry. Volume Two. Transvestism—Desire for Crippled Women. By LOUIS S. LONDON, M. D. 129 pages, including index. Cloth. Corinthian Publications. New York. 1952. Price $2.50.

Volume Two of *Dynamic Psychiatry* is a small, complete work in itself. There is a short historical and anthropological discussion of the transvestite perversion. It is followed by 50 illustrations of considerable artistic merit to show the fantasy life of the illustrator-patient, who dressed as a woman, practised shoe fetishism and had a pathological interest in crippled and deformed women. The illustrations are followed by a short report of the patient's successful analysis.

Live and Help Live. By S. H. KRAINES, M. D., and E. S. THETFORD. 408 pages. Cloth. Macmillan. New York. 1951. Price $3.75.

Underlying the common-sense advice presented by the authors is a sound psychiatric sense. The rapid alternation of paragraph, case history, and outline form combines appeal, example, and rules-for-thinking in a dramatic, readable style. From time to time, ancient religious wisdoms are correlated with modern terminology. The professional reader will be interested only if searching for techniques to aid him in popular presentation of his subject. The reader seeking help will find tangible mental exercises and will be more stimulated to self-action than by most books, although the authors have not created a substitute for psychotherapy. Rooted in the everyday experience of everyone, this should provide a good stimulus for group discussion.

The Rosenberg Case. Fact and Fiction. By S. ANDHIL FINEBERG. 159 pages including index. Cloth. Oceana Publications. New York. 1953. Price $2.50.

The case of the executed atom spies, Ethel and Julius Rosenberg, was the occasion for a notable outburst of Communist propaganda. It was highly successful in raising the false issue of anti-Semitism here and abroad, and with this and other misrepresentations did irreparable harm to America's repute in Europe.

The author of this report on the Rosenberg case is director of community service of the American Jewish Committee, a member of the Central Conference of American Rabbis, and a widely-known figure in religious education, in which he holds a doctorate from Columbia University.

The uproar over the Rosenbergs was produced by deliberate irritation of numerous sources of mass pathology. A murky and unpleasant atmosphere still surrounds the case in the minds of many people, and Dr. Fineberg's book is a brief but factual and useful exposition of the means to dispel it.

Patterns of Marriage. A Study of Marriage Relationships in the Urban Working Classes. By ELIOT SLATER and MOYA WOODSIDE. 303 pages. Cloth. Cassell & Company, Ltd. London. 1951. Price $4.00.

This book is a report on a study during World War II in a hospital in England, populated primarily by British soldiers. The authors gathered data on a group selected as follows: "Only those men would be taken who would cooperate with the investigation and would give a reasonable guarantee that their wives would help too. . . . " Detailed histories were taken from both the patients and their wives, and general conclusions were drawn as to family background, childhood, education, occupation, sports, hobbies and sociability.

The authors attempt some analysis of these histories, discuss the effect of war on marriage, and go into some detail in comparing the neurotic with the normal in terms of marital success and happiness. They conclude—as might be expected—that neurotics tend to marry neurotics and that such marriages, based on "less realistic reason," show more deficiencies in adjustment and are, on the whole, less successful.

The concluding section of the book is composed of statistical tables, but although an attempt at statistical analysis permeates the text, it is on the whole a simple reporting of marital conditions and attitudes expressed by a rather narrow (generally London working class) segment of the British population. The reviewer felt that the women interviewed may have been somewhat more loquacious than their spouses. The book is also, in spite of its anecdotal tendency, a contribution to a field where little work has been done and much is needed.

Child Psychiatric Techniques. By LAURETTA BENDER, M. D. 335 pages including index. Cloth. Color plates. Thomas. Springfield. 1952. Price $8.50.

Child psychiatry lures psychiatrists, with few exceptions, onto uncertain ground. Lauretta Bender is one of the few who can speak with any authority on this subject. This work helps fill in the gap between understanding the fundamentals of human personality development and comprehending the aberrations of childhood. Beginning with a brief survey of the methods available for use in child psychiatry, including psychological testing, play techniques, behaviorism, etc., Dr. Bender deals with the various projective techniques used in the investigation of childhood problems, particularly those involving "form problems." Concerning the latter, she states, "The child's experimentation with form and configuration is an expression of its tendencies to come to a better handling of objects by action," and, "these form problems lead to emotional problems—problems of destruction, preservation and protection. We are of the impression that the emotional problems and the so-called form problems are in essence identi-

cal." Under the heading of "form problems" are included sidewalk games, graphic art, play with toys, etc. She sees a definite progression in the use and mastering of "form" as the child matures. "Our experience would lead to the conclusion that the child actually experiments with the different phenomena [of form], getting satisfaction with each new experience which is complete enough for that stage of maturation of the developing organism growing from preceding experience levels."

Motor *Gestalten* is next delved into, with graphic examples of *Gestalt* reproductions by normal and abnormal children. The author is convinced of the value of Motor *Gestalten* and explains what she thinks are the patterns to be expected in the case of specific abnormalities of personality.

Dr. Bender emphatically states that drawings of children are invaluable aids in understanding underlying emotions, stresses and strains. "The content, the chosen color and form principles can only artificially be isolated from the life problems of the individual. Every art production has to be studied from the point of view of whether it expresses the desire for a fully developed reality, whether it is an attempt to escape from reality, whether it is an overcompensation, or a magic gesture." Accompanying the author's discussion and analysis are numerous interesting, fully-explained examples of child art.

Group activities are then discussed at length and are classified as being of great benefit to the psychiatrist and psychologist both in investigation and in therapy. Included are classes, group dances, plays, etc. The remainder of the book deals with the therapy of the problem child, principally through the use of psychotherapy with graphic art, clay, the dance, puppets and group activities as adjuncts.

This is an extremely useful, interesting and timely book, facilitating greatly the understanding of childhood play and art, and the therapeutic aids derived therefrom.

People's Padre. By EMMETT MCLOUGHLIN. 288 pages including index. Cloth. Beacon Press. Boston. 1954. Price $3.95.

Emmett McLoughlin has written a somewhat condensed autobiography, covering 14 years in the Franciscan Order of the Roman Catholic priesthood and his career since his break with the Church in 1948. Both as a priest and a layman, McLoughlin has been administrator of a more than 200-bed general hospital in Phoenix, Arizona.

His book conveys an idea of the difficulties of running a genuinely interracial hospital in the Southwest, as well as giving his own version of his difficulties with the Church. Persons concerned with hospital administration should find much of interest here. The more personal side of the account appears to be non-fanatical, but does not present inner motivations as fully as a psychiatrist might wish.

Cyclone in Calico. The Story of Mary Ann Brickerdyke. By NINA BROWN BAKER. 254 pages. Cloth. Little, Brown. Boston. 1952. Price $3.50.

This book is written as well as—and is fully as interesting as—any novel. It is really the biography of a kindly yet forceful woman who attacked the scandalous methods of caring for Union soldiers in the early stages of the Civil War. She changed the filthy, plague-disseminating hospital at Cairo, Mo., into a clean, well-conducted institution. In these days, with nursing care given by young pretty nurses in well-equipped hospitals, it is difficult to understand the animosities directed against any hospital and the prejudicial attitude toward organized medical care which was shown in the middle nineteenth century.

Medicine owes a lot of credit to such women as this determined person, Mary Ann Brickerdyke. She was the Dorothea Dix of the Middle West. These two women were doing, apparently unknown to each other, the same organizational work except that Mary Ann was far away from the "top brass" in Washington, D. C., and had to do everything herself. Mary Ann did not organize the army nurse corps as Miss Dix did but she did make a corps of practical nurses out of the rugged women of the west.

This biography is an exciting one and it is hard to lay the book aside until one has finished reading it. It will be especially inspiring reading for nurses and should be in every nurses' library.

A Doctor Talks to Women. By SAMUEL RAYNOR MEAKER, M. D. 231 pages. Cloth. Simon & Schuster. New York. 1954. Price $3.95.

A Doctor Talks to Women is what its title implies, a frank discussion of the female body with its normal and abnormal functioning. For anyone with an average education in the biological sciences it can prove fascinating. Dr. Meaker is a practising gynecologist; and, besides displaying competence in his field, he shows himself to be a humorist, a humanist and a very practical man. His illustrations are simple; his descriptions are concrete and understandable. There is a discussion of planned parenthood.

This book is recommended for any woman who wants to know about herself, and for any man who wants to increase his own understanding.

The Little Stockade. By NATALIE ANDERSON SCOTT. 254 pages. Cloth. Dutton. New York. 1954. Price $3.50.

The Little Stockade is by a well-recognized author and was published with unusual efforts at publicity. It is a story of cheap prostitution. This reviewer thinks the author doesn't know her subject and certainly doesn't understand the psychology of her characters. Her people are wooden and her plot is pretty silly.

The Interpersonal Theory of Psychiatry. By HARRY STACK SULLIVAN. xviii and 393 pages. Cloth. Norton. New York. 1953. Price $5.00.

The Interpersonal Theory of Psychiatry is based on the last series of lectures given by Harry Stack Sullivan at the Washington School of Psychiatry before his death in 1949. Sullivan, organizing his theories of psychiatry into a genetic sequence which divides human development into six periods—infancy, childhood, the juvenile era, preadolescence, early adolescence, and late adolescence—attempts to explain how, "from birth onward, a very capable animal becomes a person . . . and as to how this transformation of a very gifted animal . . . is brought about, step by step, from very, very early in life, through the influence of other people, and solely for the purpose of living with other people in some sort of social organization." This analysis is followed by a brief discussion of mental disorders and their relationship to earlier inadequate and inappropriate actions in interpersonal relations.

Sullivan, as has often been noted, expresses in different terms many of Freud's views on personality development; but his interpersonal theory of psychiatry differs in many respects from orthodox psychoanalytic theory: in that it minimizes the sexual or erotic aspects of early development and instead, emphasizes the biological development of the child in terms of growth and of the interpersonal relations provided by the culture. These appear to be elements of originality worth study by all those interested in human nature; its development and acculturation.

Bright Children. By NORMA E. CUTTS and NICHOLAS MOSELEY. 238 pages. Cloth. Putnam. New York. 1953. Price $3.50.

Parents of bright children will be delighted to discover that chores and the usual things the normal child is expected to perform should be part of the unusual child's life. The children under discussion have IQ's over 120. The authors seem to feel that the child is not so much in danger of going wrong as the parent. Some of this book's advice may appear naïve, but generally it is a sound guide for parents with children of high intellectual capacity.

The Story of Ernie Pyle. By LEE G. MILLER. 439 pages including index. Cloth. Viking. New York. 1950. Price $3.95.

Aside from the general and continued interest of the ordinary reader in the life of the man who wrote of the common soldier, the psychiatrist will find this story of a tragic yet not completely unhappy marriage of great professional interest. Pyle's efforts to solve the unsolvable were frantic, unremitting and tireless. (They went to the fantastic lengths of a divorce in the hope that the shock would improve his wife's mental condition.)

How We Fought for Our Schools. By EDWARD DARLING. 255 pages. Cloth. Norton. New York. 1954. Price $3.00.

How We Fought for Our Schools is described as a "documentary novel." It presents, with a very thin veil of fiction, an attack on the public school system made in part in the guise of an attack on progressive education, and backed by such people as the Christian-Fronters and other worse-than-reactionary Fascist-minded groups. This story, told from the point of view of a suburban school committee member, recites, according to the dust jacket, events which "actually occurred." It was written in collaboration with members of the staff of the Center for Field Studies of the Harvard Graduate School of Education and its base in fact can thus hardly be disputed.

This reviewer thinks this is an important and rather frightening volume. He feels it is the more menacing in that "progressive education" has lately become the subject of severe and legitimate criticism for what the reviewer believes are obvious and serious deficiencies. This legitimate attack needs no help from the Fascist fringe and certainly welcomes none. The fact that Fascistic nationalist and anti-Semitic groups are attacking the same people that the legitimate critics do should be of even more concern to those critics—who include psychiatrists and other professional persons—than it is to the educators attacked.

Psychiatric Aide Education. By BERNARD H. HALL, M. D.; MARY GANGEMI, R. N., Litt. M.; V. L. NORRIS, A. B.; VIVIENNE HUTCHENS, A. B., P. A., and GORDON SAWATSKY, A. B., P. A. 165 pages. Cloth. Grune & Stratton. New York. 1952. Price $5.75.

Through a grant from the Rockefeller Foundation, the Menninger Foundation in co-operation with the Topeka State Hospital developed a program for the training of mental hospital attendant personnel. This book describes the recruitment and selection program used, the theoretical and the clinical curricula, the methods of teaching and the successes and failures of the program.

Nothing especially significant is revealed, but it is valuable reading for administrators who are planning such a program.

Crimes of Passion. By EDWARD D. RADIN. 247 pages. Cloth. Putnam. New York. 1953. Price $3.50.

Mr. Radin apparently identifies the "passion" of his title with sex, and disregards sexual psychological implications. His book is a factual and uninspired account, completely lacking in insight into motivation, of 11 notorious American crimes. There was opportunity here for a splendid study of how men and women involved in sexual misadventure resort to violence. It must be regretfully noted that Mr. Radin missed all the boats.

Body-Mind and Creativity. By J. HERBERT BLACKHURST. 173 pages. Cloth. Philosophical Library. New York. 1954. Price $3.00.

The book, claims the introduction, is a primer of philosophy in dialogue-form, and professes to these aims:

"The book aims first of all to give a clear statement of material monism. The book next presents an ontological structure which implies that man is a center of genuine creativity. The weakness of mentalism as found in ontological idealism is then exposed. The book maintains that neither the philosophy of the neorealist nor that of the modern pragmatist permits the view that man is the creator of his own known world. This . . . is the highest conceivable view of man."

All these divergencies of opinions among philosophers have for the dynamic psychiatrist a touch of the involuntarily comic: The unconscious is not taken cognizance of.

Give Yourself One Day. By CALVIN ROBINSON. 154 pages. Cloth. Dover Publications, Inc. New York. 1952. Price $2.00.

The author, a lawyer, teacher and lecturer, tells the reader that, in his search for his own happiness, he has "looked inside" himself and, in so doing, has learned certain principles of living which have made his life profitable to himself and to others. Because of these experiences, he wants to describe them to others.

He tells the reader how to follow his method—to look forward to each new day, to live with others, to react to work and to succeed, to live with one's personal problems, to attack family problems, and to understand God through meditation and prayer. His plain philosophy will encourage many persons who believe themselves unhappy and hopeless.

Proud Kate. By ISHBEL ROSS. 290 pages. Cloth. Harper. New York. 1953. Price $4.00.

Proud Kate is a historical novel about Kate Chase, daughter of Lincoln's secretary of the treasury. If a reader is willing to forget that unconscious motivations do exist, if he accepts the term, "ambitious woman," at face value, and is interested in female intrigues during the Civil War, he can "enjoy" all that in this book. If his taste is more refined, he will not be satisfied with documented scraps of female intrigue, and will wonder whether the rather boring heroine is worth bothering with.

The Best Is Yet to Be. By PAUL B. MAVES. 96 pages. Cloth. Westminster Pastoral Aid Books. Westminster Press. Philadelphia. 1952. Price $1.50.

This is a religious approach to old-age problems, enumerating the possibilities of adjustment. Each chapter ends with meditations; the final formulation reads: "Death must be an essential part of God's plan."

Helping Your Heart. By EMANUEL GOLDBERGER, M. D. 234 pages. Cloth. Longmans, Green. New York. 1953. Price $3.75.

It is certainly a profitable experience for the layman to find an eminent specialist like Dr. Goldberger who can describe and explain ailments of the heart in such easily understood language and in such an easy, flowing style. This book is pleasurable as well as informative reading.

Dr. Goldberger has divided his book into four sections and, in this way, describes symptoms as the patients experience them; tells what goes on in the doctor's office and the doctor's methods of examination; describes the various ills to which the heart, as an organ, is heir; and, finally, tells the reader that, if he has a heart ailment, he should live properly, exercise properly and eat properly. In this way the author helps all persons to understand heart disease better, and, to the person now suffering from heart disease, he gives facts and hope.

The Mating Instinct. By LORUS J. and MARGERY J. MILNE. 243 pages including index. Cloth. Little, Brown. Boston. 1950, 1954. Price $4.50.

The Milnes are a professor and an honorary fellow in zoology at the University of New Hampshire. This popular book is a fascinating review of well-known and little-known facts concerning mating, from the fiddler crab and termite to the octopus and the elk. According to the publisher's description, this material is presented to show its "significance to man." So far as this reviewer can see, it isn't; and in view of certain widely publicized misapplications of zoological material to man, this may be an excellent idea.

Until Victory. Horace Mann and Mary Peabody. By LOUISE HALL THARP. 345 pages. Cloth. Little, Brown. Boston. 1953. Price $5.00.

Until Victory is the complete biography of Horace Mann—and of Mary Peabody, only insofar as her life was interwoven with Mann's. Beginning with the earliest known record of the Man (former spelling) family it traces the life of Horace Mann through his career as lawyer, legislator and educator. The book is extremely well-documented and there is a considerable amount of space allocated to the love affair of Mann and Charlotte Messer, his first wife.

In parts, the author is extremely thorough and in others presents meager information on the subject at hand. In passing, Mann's work for the "pauper insane" of Massachusetts is briefly gone into. More space is devoted to his belief in phrenology. The book is enjoyable reading and gives insight into the life and loves of its central characters.

Talk It Out with Your Child. By MARY M. THOMSON. 267 pages. Cloth. McGraw-Hill. New York. 1953. Price $3.50.

The author begins by discussing the feeling of omnipotence that all young children have and then goes on—throughout the book—to have the parents, and particularly the mother, foster this belief beyond all reasonable bounds. She takes up feelings of fear, jealousy, anger, hate, castration, etc., and has the parent handle them in the simple way of merely "talking them out" in one conversation. It seems with such "psychoanalytic"-minded parents who know immediately what is bothering their child, all should be right with the world.

The book is packed with sample conversations between parent and child, at the various stages of child development. Suppose, for example, the parent is lucky enough to hit upon what is troubling his offspring. He simply turns then to the designated page and follows the pattern as laid down in the book. Woe be to the parent, though, whose child doesn't give the answers written there. There is nothing to guide at this point. And the sample answers given by these children seem, in most places, sophisticated beyond their abilities.

The book makes too simple the difficult job of raising a child.

Truth Is Our Weapon. By EDWARD W. BARRETT. 300 pages. Cloth. Funk & Wagnalls. New York. 1953. Price $4.00.

In spite of parental teachings, telling the truth has never been an easy procedure, because most persons do not want to hear the truth and, even if they do hear it, are suspicious of ulterior motives.

Edward W. Barrett, former Assistant Secretary of State, is a veteran of the so-called propaganda war and he still believes that "Truth is Our Weapon." In this book he describes his experiences in various branches of governmental information and propaganda services. He most energetically defends the use and the need of the "Voice of America." He agrees with Presidents Eisenhower and Truman that "we cannot hope to win the cold war unless we win the minds of men." "When we Americans consistently put our case before the people of the world in a way which shows we respect their intelligence, we will be on our way. . . ."

Friends and Vague Lovers. By JACK DUNPHY. 237 pages. Cloth. Farrar, Straus & Young. New York. 1952. Price $3.00.

A pretentious, cold, disagreeable novel, *Friends and Vague Lovers,* concerns a homosexual psychopath and the elderly mother of one of his transitory friends (the son ends as a suicide), who falls in love with him. The homosexual and his circle are routinely described. The mother is totally out of focus. The book is written with pomposity and complete ignorance of what unconsciously really propels the victims of perversion homosexuality.

The Tattooed Heart. By THEODORA KEOGH. 261 pages. Cloth. Farrar, Straus & Young. New York. 1953. Price $3.00.

The Tattoed Heart is the story of a girl torn by the conflicts of pubescence, which throb around: a desire to remain fixated in childhood, the struggle with misunderstanding adults, and the dawning awareness and acceptance of femininity. Those familiar with psychoanalytical theory will recognize that the theme of this story is concerned with a course of female personality development which analysts have postulated as a necessary requisite in the attainment of sexual maturity and the acceptance of the female role—that is, a libidinal shift from the genitals to the body as a whole, resulting from the repression of penis envy and that of desire to be boyish. Mrs. Keogh does not succeed in portraying her adult characters with much depth or understanding; however, her insight into the inner world of the child, which is described with sensitivity and charm, more than compensates for this flaw.

The Inside Story. Psychiatry and Everyday Life. By FRITZ REDLICH, M. D., and JUNE BINGHAM. 280 pages. Cloth. Knopf. New York. 1953. Price $3.75.

This is an extremely amusing and very informative book. It is an easy-to-read volume, relating psychiatry's basic discoveries to everyday life. The first section pertains chiefly to psychiatry and the average human being. Particularly valuable, are the chapters on humor as therapy, and those in which are discussed the recognizing of Freudian phenomena in one's self. A second section gives a picture of the present status of psychiatry, what is known about mental health and illness. And finally, the spotlight is turned on the psychiatrists themselves.

In the opinion of this reviewer the book is one of the best and most accurate of its kind. The text contains, on nearly every page, cartoons done by some of the country's leading cartoonists. For these alone, the volume should be a must in anyone's library. There is also a glossary of psychiatric terms, an excellent bibliography, and a list of national agencies for mental health.

The Hornbeam Tree. By CID RICKETTS SUMNER. 297 pages. Cloth. Bobbs-Merrill. Indianapolis. 1953. Price $3.00.

Set against the background of modern Puritanical New England, *The Hornbeam Tree* has as its central theme the question: What is one to do when one has reached the half-century mark without any past to look back upon? The problem is faced by many people approaching later life, with desperate hopes of holding onto youth. The book is well written and the author makes excellent use of minor characters. On the whole, it is an enjoyable novel.

A Speculation in Reality. By IRVING F. LAUCKS. 154 pages. Cloth. Philosophical Library. New York. 1953. Price $3.75.

This book is explicitly what the title states—"a speculation in reality." It is attended by a scattering of data and hypotheses from physics and chemistry, with an attempt at integration, to explain "soul-stuff," or the apparently existing non-material aspect of nature, as supposedly revealed in psychical phenomena. In the course of the author's borrowings, he journeys through rather wide and disparate, though potentially interesting, regions of science; but he does not succeed in attaining firm foothold in any. One of the more plausible sections in the book, and one which will probably prove to be of most value to the reader of this journal, deals with instinct as consisting of physico-chemical processes and reactions. This argument is more ably advanced and buttressed with empirical data than are others, and certainly is not inconsistent with an enlightened scientific attitude.

The chapter, "How the Soul Develops," may contain sufficient warning, or invitation, depending upon the prospective reader's attitude. In general, the author begins this flight of fancy from a relatively secure and empirical scientific platform; but before long he has winged his unstable way into regions of intellectual limbo, with musings on the "permanence of the soul," hypnosis, communication from "the special protein molecules of the structure of the brain and nerves to the soul" through a "hypothetical" radiation termed "A-rays."

These Items of Desire. By LOUIS A. BRENNAN. 376 pages. Cloth. Random House. New York. 1953. Price $3.50.

The author describes a series of deeply masochistic personalities without the slightest understanding of what it is all about. To be "modern," he dutifully misunderstands the Oedipus complex. Allegedly, he writes about a young girl's search for the "meaning of love." The author reflects his heroine's life accurately only at one point: She is in the advertising business; hence he copies the style of that business, according to the gag, "15 per cent commission, 85 per cent confusion." It is a pity that the author is psychologically uninformed; one might have done something with the interesting material, especially the girl's mother.

Practical Psychology. By KARL S. BERNHARDT, Ph.D. xii and 337 pages. Cloth. McGraw-Hill. New York. 1953. Price $3.75.

A second edition of a book first brought out in 1945, this is designed as a text and as an introduction to psychology for those who do not intend to follow the field intensively. The outlook is definitely not Freudian, the one reference to his work being rather derogatory in tone. The make-up of the book is satisfactory, and it will serve its purpose—remembering that the coverage is confined to superficial levels.

Psychology of Industrial Relations. By C. H. LAWSHE. 339 pages. Cloth. McGraw-Hill. New York. 1953. Price $5.50.

The mention of the word psychology conjures up into the minds of many men in high managerial positions, visions of couches, mind reading, or hypnotism. Lawshe's *Psychology of Industrial Relations* does much to dispel such erroneous notions.

The book presents in nontechnical language the role of industrial psychology in the modern industrial world. Beginning with the basic problem of what motivates the average person in everyday life, it carries over this person to an industrial setting where it is pointed out that what makes people tick in life in general, makes people tick on the job. It shows clearly how an understanding on the part of management of basic motivations, both for security and independence, can make the difference to the employer of failure or success.

Putting the right person in the right job is a number one cardinal principle in any well-run organization, and Lawshe points out various techniques used to accomplish this. There are several chapters on employee and group relations, and space is also devoted to problems of making work easier and establishing equitable pay.

This is a compilation of the efforts of seven men in education, industry, the army and the navy. Considerable profit should be derived from its reading by the people for whom it is primarily written.

Essays on Sociology and Social Psychology. By KARL MANNHEIM. 319 pages. Cloth. Oxford University Press. New York. 1953. Price $6.50.

One of the early pioneers in the effort to utilize psychological methods and findings in sociology was Karl Mannheim. In these papers, extending in time from his early doctorate to shortly before his death in 1947, are presented the products of one of the more fertile and imaginative social psychologists.

Living in Germany until 1933, when he was driven from his chair in Frankfurt by the Nazis, Mannheim developed his concept of society which had important impact upon the growth of a psychologically-aware sociology. His basic concept was the "structure" of social reality, which, with the position of individuals and groups within it, "determined thinking and action and guided it into intelligible channels." Structure was comprehensive, was a dynamic entity and an intelligible principle with "goal-directedness."

However, the advent of Hitlerism, forcing Mannheim to withdraw to London, brought him to understand the phenomena of totalitarianism in

more adequate terms; his own conception of society was not sufficient to explain logically the mass, enthusiastic growth of Nazism. In searching for new methodological tools, he turned to psychoanalysis. From the resulting fusion of psychoanalysis and sociology, he arrived at the conclusion that the origin of totalitarianism lies in "collective security—a situation which arises when institutions established to allay deep-seated anxieties are no longer able to exercise this function under changed conditions." And thus, the "problem of totalitarianism . . . becomes one of psychopathology."

It is important to notice that Mannheim insisted that while incorporating psychological techniques and findings into its working field, sociological analysis cannot become identical with psychology. For the psychology of the group is not the sum total of the psychology of its individuals, which would not reveal the dynamics of the group. These papers contain material both of historical and contemporary importance which hitherto was only to be found widely scattered in a few professional journals. For psychiatrists and psychoanalysts, this book should prove stimulating reading; for the social psychologist, it will be a helpful reference work.

Let It Come Down. By PAUL BOWLES. 311 pages. Cloth. Random House. New York. 1952. Price $3.50.

The "shallowness" of modern society has occupied the time of many of our modern writers. Paul Bowles' technique involves the use of North Africa—this time the International Zone of Tangier—as a scene presenting the differences and intermingling of a corrupt society with the setting.

The faults, as one reads this book, are only too evident, while the virtues are harder to define. As yet the author has not learned to pace himself, the result being that the reader is precipitated into the story and has to plough through pages of random dissertations when the "climax" is approaching. The portrayal of the sordid, while in itself an object of the story, is done with a lack of subtlety that makes the responses of the characters seem unreal. Perhaps the most telling point this reviewer can make for the book is that he found it worth while to comment on these individual faults at all, for the book has many positive entertainment values.

The Circle of the Minotaur. By STUART HOOD. 157 pages. Cloth. Viking. New York. 1950. Price $2.50.

Hood recounts a story of violence and tragedy in postwar Italy. It is not arresting or exceptionally brilliant but it is well written and it does much to convey the feeling that the novel's hero brought about his own downfall, though without clear indication of his motivation. Without being profound, this is—as so-called psychological novels go—at least a minor achievement.

What's Your Problem? By ALFRED BLAZER, M. D. 372 pages. Cloth. Citadel. New York. 1953. Price $3.50.

Dr. Blazer has selected the questions most frequently asked by readers of his newspaper column on behavior problems and has set down his answers to them in this book. Nearly 200 problems are discussed, ranging from the value of shock therapy to marital infidelity and psychogenic obesity.

"I set myself the goal of trying to answer such questions in the commonsense language of the people without sacrificing scientific accuracy." The author does succeed in presenting his material in clear nontechnical language and in discussing questions of a general popular interest. However, there is reason to question whether scientific accuracy has not been sacrificed as a result of short-cut abbreviated approaches to very basic questions. He makes concise dogmatic statements such as "if an adolescent does not masturbate, he is emotionally maladjusted and on the way to becoming a neurotic problem" and "six people out of ten are capable of being hypnotized." The sophisticated reader will be disturbed by his treatment of controversial material on sexual problems, seeing it as primarily a reflection of the author's system of personal values rather than of objective fact.

There is much merit to this book for the reader who wishes a painless introduction to the dynamic approach of modern psychiatry. Blazer's orientation is of the William Alanson White school, and his chapters on fundamental concepts of psychotherapy reflect his training. The section of the book dealing with problems that the patient undergoing therapy faces may prove very helpful to readers contemplating, or in, analysis.

Stars in the Water. By JOHN APPLEBY. 186 pages. Cloth. Coward-McCann. New York. 1953. Price $2.75.

A mystery story is dressed up as a "psychological novel," according to the publisher's statement. It is just the opposite, as two murders are committed with only banal explanations adduced. No attempt is made to explain the murderer.

The Time of the Assassins. By GODFREY BLUNDEN. 375 pabes. Cloth. Lippincott. Philadelphia. 1952. Price $3.75.

This is an interesting novel on the totalitarian mind in action, written by an Australian war correspondent, who takes as example the fate of Kharkov during the Nazi occupation. The book is poorly balanced: Whereas Nazi brutalities are described at length, the parallel Russian attitude is not worked out. Since totalitarian minds work identically at the right and left, one wonders about the omissions.

The Troubled Mind. By BEULAH C. BOSSELMAN, M. D. 206 pages. Cloth. Ronald Press. New York. 1953. Price $3.50.

In a relatively few pages, Dr. Bosselman has accomplished a good deal. She presents a clear, concise account of personality development from infancy through old age; she surveys the different kinds of psychiatric treatment available; and she presents strong arguments for the value of psychotherapy conducted by nonmedical practitioners.

In surveying each stage of emotional development she shows what maladjustments can occur and how they are likely to reach serious proportions unless corrected. As a practising psychiatrist concerned with the need for more readily available help for the maladjusted, she indicates, in a special section on treatment methods, the many ways in which psychologists, social workers, and clergymen, as well as psychiatrists, can contribute toward meeting this need.

Although primarily written for the layman, this book should serve the needs of psychiatric workers who wish a current review of fundamental mental hygiene principles written with a minimum of unnecessary technical verbiage and a maximum of clear authenticity.

The Earliest Stages of Delinquency. By H. EDELSTON. 200 pages including index. Cloth. E. & S. Livingstone, Ltd. Edinburgh and London. 1952. Price $2.50.

Commendably broadminded, the author summarizes his conception of the delinquency problem with a quotation from William Healy: "The dynamic center of the whole problem of delinquency and crime will ever be the individual offender." The point is bravely made, that no panacea of judgment or punishment is flexible enough to apply to each and every wayward youth without occasionally doing more harm than good. The author readily admits that no solution is at hand, but points out that children's courts, child guidance clinics, and home counseling can do much to improve a deplorable situation.

An excellent review of how to conduct an effective child guidance clinic, with examples, and case histories, is the high point of this worthwhile book.

The Handwriting Analyzer. By JEROME S. MEYER. 101 pages. Cloth. Simon and Schuster. New York. 1953. Price $2.95.

This book pretends to be somewhat more than what it is. According to the publishers "it provides many hours of entertainment as well as interesting information about old friends and new. *The Handwriting Analyzer* is so accurate that it can be recommended for personnel work in business." The author is not a professional psychologist, and there is no evidence that any careful research studies substantiate the validity of the character analyses given. Whereas no objection can be leveled at its use as a game for parlor entertainment, the book should not be used for serious purposes.

The Great Corinthian. By DORIS LESLIE. xii and 251 pages. Cloth. Oxford University Press. New York. 1953. Price $3.50.

No book dealing with George IV can be really uninteresting; but at times one can be exasperating, as this one is. Young ladies hearing news "with a fainting heart" belong to an era now happily dead and buried. And while the short one-sentence paragraph, used for effect, may have its place, when the author comes up with a one-paragraph gem such as "She had been most abominably used," this reviewer is not impressed. The author on one occasion pays lip service to the idea that George IV was infatuated with older women—probably because they represented a mother-figure to him—but in general she carefully avoids allowing any such "new-fangled" ideas to mar her romantic little narrative.

The Bronte Story. By MARGARET LANE. xii and 368 pages. Cloth. Duell, Sloan & Pearce; Little, Brown. New York. 1953. Price $5.00.

Margaret Lane has reworked and expanded Mrs. Gaskell's life of Charlotte Bronte to cover the entire Bronte family, and has worked in the results of later research. This is not just a re-editing, but a complete rewriting, for, while there are lengthy sections of Mrs. Gaskell's prose included, these impose no limitations upon the form but rather serve to complement Margaret Lane's work. The Bronte family was undoubtedly one of the finest collections of assorted neurotics at large, and the author recognizes this and attempts to supply some of the background. While her book cannot be considered a true psychiatric study, neither is the subject glossed over. This reviewer found the book enjoyable, and that while exacting in its scholarship, it still avoids the deadening "doctor's thesis" approach.

The City of Anger. By WILLIAM MANCHESTER. 474 pages. Paper. Ballantine Books. New York. 1953. Price 50 cents.

This fast-moving story concerns the numbers racket in a large city, political corruption, suckers, victims, etc. Disarming is the lack of obligation observable in the author to give his dramatis personnae something like a psychological substructure. The peculiar combination of half book-knowledge ("like most promiscuous girls, her enjoyment of sex was small, and she never knew love," p. 73) and complete naïveté ("Ruby's tortured psyche was begging for liquor," p. 80—this as explanation of alcoholism) is remarkable.

Our Doctor. By MICKEY HUME. 288 pages. Cloth. Exposition. New York. 1951. Price $3.50.

Hume writes an artless, well-meaning story about a sacrificial physician. The man is good and full of virtues; unfortunately, he lacks motivations.

To End the Night. By ALEX GABY. 243 pages. Cloth. David McKay Co., Inc. New York. 1952. Price $2.75.

The author of *To End The Night* has devised a psychologically-oriented plot which concerns an army lieutenant's investigation of the motive for his wife's suicide and his search back to her childhood days for the solution. The reader is given a lucid account of the dead woman through the memories and recollections of her husband, her family and her friends to show why a woman deeply in love with her husband and happy because she was soon to bear his child would suddenly take her life. This book falls short psychologically, because the writer relies for effect and impact on revealing and uncovering a hidden chain of circumstances, rather than on personality or character structure.

Forty-Four Gravel Street. By BEN MADDOW. 254 pages. Cloth. Little, Brown. Boston. 1952. Price $3.50.

When you turn to the first page of a novel you oft-times wonder what the book is all about. When you turn to the last page of *Forty-Four Gravel Street* you are still wondering.

A man searches (vainly) for his wife at 44 Gravel Street where the wife has never been and throughout the whole book never appears. He encounters a number of strange characters whose lives have no bearing upon his own and whose existences are never tied together in any possible way. There is a suicide, a murder, a seduction, the birth of twins, a robbery, a mystic healer, and an abandonment.

If Mr. Maddow is trying to be mystifyingly symbolic, he at least succeeds in being mystifying.

How Thin the Veil. A Newspaperman's Story of His Own Mental Crack-up and Recovery. By JACK KERKHOFF. 311 pages. Cloth. Greenberg. New York. 1952. Price $3.50.

The author, suffering from severe depression, and having several times contemplated suicide, voluntarily enters a state hospital near his childhood home. Then ensues a rambling, somewhat disjointed, and occasionally interesting account of with whom, where, and how he spent his time. The book's chief failing lies in the author's only too successful attempt to present the actually somewhat stark, sometimes crude, life in a mental institution, in a genteel fashion. This work has little to offer anyone who is after more than frivolous reading.

Women Are My Problem. By J. L. BUBIS. 223 pages. Cloth. Comet Press. New York. 1953. Price $3.00.

This is the autobiography of a distinguished obstetrician and gynecologist. The book confirms convincingly the fact that every pioneer has to fight malice, ignorance, conservatism. The author delivers his attacks in a cultured and restrained manner.

new directions 14. xvi and 408 pages. Cloth. New Directions. Norfolk, Conn. 1953. Price $5.00.

These annual prose and poetry anthologies are supposed to represent a method of expression for new writers. This anthology, however, could better have been titled "Modern Writing," as most of the more important contributions are by well-established authors. As might be expected, analytical concepts color many of the selections—but in no case is the handling of the theme sufficiently expert to warrant recommendation on *that* score alone. In one article, *"Struwwelpeter"* by Rudolph Friedman, which purports to be a psychoanalytic study of a German children's book, the techniques employed are so "slovenly" as to make them useless. The author makes the statement that "analysis is more and more returning to the folk-viewpoint that excessive masturbation leads to early death." Far from being a "new direction," this reviewer regards this unsubstantiated statement as little more than a return to barbarism.

The General's Wench. By ROSAMOND MARSHALL. 244 pages. Cloth. Prentice-Hall. New York. 1953. Price $3.50.

Not only detective story writers, but also historical novelists, have found that sex is more salable if it is spiced with liberal dashes of sadism. In this case, it has proved convenient to introduce the sadism by putting the fair heroine in the clutches of two successive madmen—after all, it has become so usual for the said fair heroine to rest languorously in the bed of the stalwart hero that something else has to be added to the formula. Needless to say, this book adds nothing to dynamic psychological fiction—and in this case nothing is added to the understanding of history either. As a point of interest the story takes place in London under George III, not that this is important.

Be Happier, Be Healthier. By GAYLORD HAUSER. 278 pages. Cloth. Farrar, Straus & Young. New York. 1952. Price $3.00.

According to the author, a person will "Be Happier, Be Healthier" if he will use, to advantage, nature's assets, the sun, the earth, the air, the water. He makes the diet recommendations to be expected from this author. This book will appeal mostly to the person who is constantly worrying about his health and who is constantly looking for reassurance.

Courtship and Love. By WILLIAM S. SADLER, M. D. 209 pages. Cloth. Macmillan. New York. 1952. Price $3.50.

Dr. Sadler, a psychiatrist, has drawn upon 40 years of experience to write on love, courtship and marriage. The book is directed to young people and, perhaps because of this, over-simplified advice is offered.

CONTRIBUTORS TO THIS ISSUE

BERTRICE FARRALL CLARK. Mrs. Clark, an occupational instructor at Marcy and Rochester state hospitals from 1946 to 1953, now lives in Churchville, N. Y., where she lists her present occupations as keeping house in a small apartment, weaving men's mufflers and baby blankets, working on a book of crafts, and enjoying the church and community life of her village. A graduate of Vassar College in 1912 and of Cornell Agricultural College in 1914, Mrs. Clark was a farm manager, a research chemist, a private secretary and a county leader of boys' and girls 4-H Clubs until her marriage in 1921.

From 1927 to 1930, she conducted handicraft classes for the small children of Stanford University faculty members; later, returning to the east, she did commercial weaving at home, worked with marionettes for churches, schools and other organizations, directed handicraft work at Girl Scout camps, taught adult classes, and did radio and other lecturing on craft subjects. Following work during World War II as an inspector of scientific instruments for war use, she joined the New York State Department of Mental Hygiene as occupational instructor in 1946.

MRS. F. H. Mrs. F. H. is the pseudonym of a former patient of Sándor Ferenczi. The incidents reported in her paper in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT occurred during treatment for a neurosis she reported in the journal *Psychiatry* in May 1952, "Recovery from a Long Neurosis." She attributes her final recovery—much later—to the association with Ferenczi recorded here. The paper in this issue of THE SUPPLEMENT was contributed to this journal at the suggestion of Mrs. Izette de Forest, a practising analyst for some 25 years, who was trained by Ferenczi.

WALTER S. BOERNSTEIN, M. D. Dr. Boernstein trained in experimental physiology at the Physiological Institute, Frankfurt am Main, and in neurology and psychiatry at the University Clinics in the same city. He later did extensive research in physiological psychology in Frankfurt and continued this at the Psychological Institute of the University of Berlin. During the Hitler regime, he did experimental work at the London School of Economics laboratory of biology under Professor Lancelot Hogben and at Yale University. He has been in psychoanalytic work in New York City for the last 10 years. His principal lines of research are in the field of the mutual relations of perceiving and personality.

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FREDERIC G. WORDEN, M. D. Born in Syracuse, N. Y., Dr. Worden received his medical degree from the University of Chicago in 1942. After a medical internship at the Johns Hopkins Hospital, Baltimore, he served as house officer, assistant resident, senior assistant resident and resident in the Henry Phipps Psychiatric Clinic there. He has been a student in the Washington Baltimore Psychoanalytic Institute since 1947. From July 1950 to July 1952 he was clinical director, The Sheppard and Enoch Pratt Hospital, Towson, Md., and later was supervisor of psychotherapy at the Sheppard and Enoch Pratt Hospital, instructor in psychiatry, at the Johns Hopkins University, and psychiatrist, at the Johns Hopkins Hospital.

He is at present assistant professor of psychiatry, U. C. L. A. School of Medicine, at Los Angeles.

JOHN D. PATTON, M. D. Dr. Patton received his bachelor's degree from St. Joseph's College of Indiana in 1942, and his medical degree from the St. Louis School of Medicine in 1945. He had a rotating internship at Church Home and Hospital, Baltimore, from 1945 to 1946. From 1946 to 1948, he served in the Medical Corps, AUS, as a first lieutenant and captain, at which time he was assigned to the Veterans Administration Hospital, Perry Point, Md. After discharge from the service he continued there as a staff physician from 1948 to 1949. He served as chief of service, at The Sheppard and Enoch Pratt Hospital, Towson, Md., from November 1949 to June 1952 and is at the present time clinical director of that hospital. He is also an instructor in psychiatry, at the Johns Hopkins School of Medicine and is psychiatrist in the outpatient department at the Johns Hopkins Hospital. Since 1948, he has been a student in the Baltimore Psychoanalytic Institute.

GERDA WILLNER, M. D. Dr. Gerda Willner is a graduate of the University of Vienna in 1936. She served a rotating internship in various hospitals in Vienna and came to this country in 1938, when she again served an internship in a general hospital in Wisconsin. She went to the Central Islip (N. Y.) State Hospital in 1943 and is at present a supervising psychiatrist there. She is a fellow of the American Psychiatric Association and a member of other professional societies and is a diplomate in psychiatry of the American Board of Psychiatry and Neurology.

EDMUND BERGLER, M. D. Dr. Bergler is internationally known as a psychoanalyst, writer and research worker. His recent publications include: ***Kinsey's Myth of Female Sexuality*** (in collaboration with William S. Kroger, M. D.), ***Fashion and the Unconscious***, and ***The Revolt of the Middle-Aged Man***. He is a frequent contributor to THE PSYCHIATRIC QUARTERLY and SUPPLEMENT, and the paper appearing in the present issue is a continuation of a discussion previously presented here. Dr. Bergler is a graduate of the medical school of the University of Vienna and was formerly assistant director of the Vienna Psychoanalytic Clinic. He was widely known in professional circles in Europe before coming to this country; and his scientific publications, now numbering considerably more than 100 books and articles, have been published in Europe as well as in this country. He is at present in private psychoanalytic practice in New York City.

CARNEY LANDIS, Ph.D. Dr. Landis is principal research scientist (psychology) at the New York State Psychiatric Institute, New York City. He has been in charge of the department of research psychology there since 1930. He is also professor of psychology at Columbia University. He is author or co-author of numerous scientific publications, including about 10 previous publications in THE QUARTERLY and SUPPLEMENT.

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Dr. Peters is a graduate of the University of Arkansas; he received his masters' degree from the University of Missouri and his doctorate from the University of Chicago. He was assistant professor at the University

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Dr. Peters is a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology. His particular areas of interest have been group psychotherapy, evaluation of treatment methods and diagnostic test development.

RICHARD L. JENKINS, M. D. Dr. Jenkins is chief of psychiatric research of the Veterans Administration. A graduate of Stanford University and of Rush Medical College, University of Chicago, he was a Rockefeller fellow in psychiatry from 1936 to 1938 and trained with Adolf Meyer at the Johns Hopkins Hospital, Baltimore. He has been particularly concerned with the development of research and of a more satisfactory scientific orientation in the psychiatric field. He is author of numerous scientific articles and of a just-published professional book, ***Breaking Patterns of Defeat*** (J. B. Lippincott Company, Philadelphia, 1954).

ROBERT S. MORROW, Ph.D. After receiving his Ph.D. in psychology from New York University in 1940, Dr. Morrow joined the research team studying the causes and effects of the use of marihuana, which resulted in the co-operative publication of ***The Marihuana Problem in the City of New York.*** Following this, he joined the navy, in which he now holds the reserve rank of lieutenant commander.

Dr. Morrow joined the Veterans Administration in 1946 and became chief clinical psychologist in the Bronx (N. Y.) Veterans Administration Hospital in 1948. He has been a member of the psychology department of the College of the City of New York since 1946, has been a visiting lecturer at New York University, and for the summer of 1954 has been appointed visiting professor of psychology at the University of Puerto Rico.

He is a fellow of the American Psychological Association and a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology, for which he has also been an examiner. He has been a special examiner for the New York State Civil Service Commission and is author or co-author of a number of research and theoretical papers.

CHESTER C. BENNETT, Ph.D. Dr. Bennett is professor of clinical psychology the School of Medicine and Graduate School faculties of Boston University, where he directs the program of doctoral training in

clinical psychology. He is consultant to the Veterans Administration and was formerly with the Veterans Administration (1946 to 1948) as branch chief clinical psychologist in Boston. He has taught at Columbia University, where he received his Ph.D. degree in 1938, and has also served on the faculties of Missouri, Rochester, and Harvard Universities. He was clinical psychologist at the Rochester Guidance Center from 1934 to 1940. As a naval officer during the war he was engaged in aviation research. He is a fellow of the American Psychological Association and the Massachusetts Psychological Association and is the author of papers in the *American Journal of Orthopsychiatry* and elsewhere.

JOHN ARSENIAN, Ph. D. Dr. Arsenian has been head psychologist at Boston State Hospital since 1947. Concurrently, he has served as assistant professor in clinical psychology at Boston University and research associate in the department of social relations, Harvard University, where he received his graduate training. He is an associate member of the American Psychological Association, a member of the Massachusetts Society for Research in Psychiatry, and co-author of a number of scientific articles.

WILFRED C. HULSE, M. D. Dr. Hulse received his pre-medical and medical training in Germany and is a graduate of the University of Breslau, 1924. He did post-graduate work in Berlin and in Paris. During World War II he served as neuropsychiatrist with the United States Army in Europe for two years. He is a practising psychiatrist in New York City with special interest in child psychiatry and psychotherapy and its different branches. He has published papers on psychotherapy in general practice, on group psychotherapy, child psychiatry, and the relations between psychiatry and art.

Dr. Hulse is chief psychiatrist at the Children's Center, Bureau of Child Welfare, New York City; adjunct psychiatrist and chief of the child guidance clinic of Mount Sinai Hospital, and clinical associate professor of psychiatry at the Medical College of the State University.

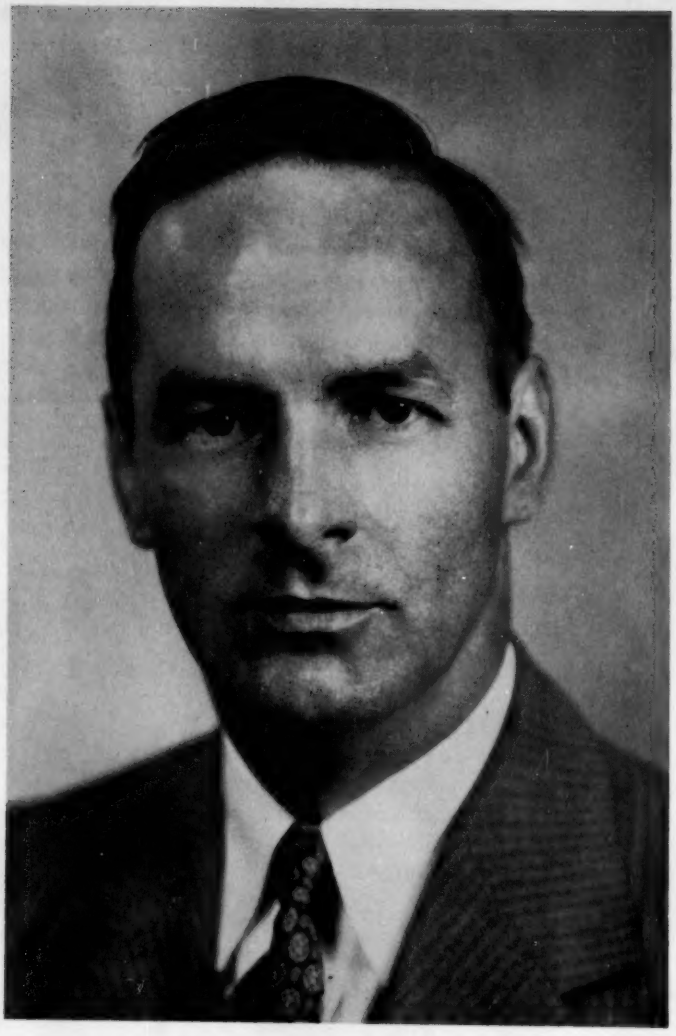
MARY DECORATO VERGARA, A. M., M. S. Mrs. Vergara has had an extensive career in teaching, social work and international relations. A graduate of Hunter College, of Teachers College, Columbia University, and of the New York School of Social Work, Columbia University, she has been a YWCA adviser for girls, a teacher, manager of the student exchange at Hunter College, and field worker and supervisor for the Department of Welfare of the City of New York.

During World War II, Mrs. Vergara was director of social services, and territorial director, for the Pacific area of the United Seaman's Service.

She has been a chairman of the Minority Problem Group and president of the New York Alumni Chapter of International House; and she has had a variety of teaching experience in sociology and social work. She was director of Psychiatric Social Service at the Children's Center, Department of Welfare, City of New York, from 1947 to 1952. After another period of professional work in the Far East (Japan) she has recently returned to New York City.

RUTH E. WHITFIELD, M. S. Miss Whitfield is a graduate of New York University and of the New York School of Social Work. She is a psychiatric social worker with wide experience in juvenile delinquency, foster care, family case work, and medical social work.

Miss Whitfield has worked with the Red Cross and with hospitals and courts. She has been a psychiatric social worker at the Children's Center, Department of Welfare, New York City, since 1948.



LAWRENCE C. KOLB, M. D.

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Lawrence C. Kolb, M. D., consultant in psychiatry at the Mayo Clinic and associate professor in psychiatry of the Mayo Foundation, Graduate School of Medicine, University of Minnesota, has been named director of the New York State Psychiatric Institute as of July 1, 1954. At the same time, he will become professor of psychiatry and executive officer of the department of psychiatry, Columbia University College of Physicians and Surgeons, and director of the psychiatric service of Presbyterian Hospital, New York City. The state appointment was made by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene, and the university appointments by Dr. Willard C. Rappleye, dean of the Columbia faculty of medicine. Dr. Kolb succeeds Nolan D. C. Lewis, M. D., as director of the Institute; Dr. Lewis retired on September 1, 1953.

The Psychiatric Institute is the center of the department's research, training and teaching program. Dr. Kolb will head it with a wide background of research and consulting experience. Besides his responsibilities at the Mayo Clinic and the University of Minnesota, he is now a member of three National Research Council committees—dealing with psychiatry, naval medical research, and problems of alcohol. He is consultant to the National Multiple Sclerosis Society; and his work in Minnesota has included membership on the governor's advisory council on mental health, chairmanship of the research advisory committee to the state commissioner of welfare, and consultant on the advisory committee to the counseling clinic, Public Health Center, Rochester, Minn.

Born in Baltimore, Dr. Kolb is a graduate of Trinity College, Dublin University; and he received his medical degree from Johns Hopkins in 1934. He interned in medicine and surgery at Strong Memorial Hospital, Rochester, N. Y., then returned to the Johns Hopkins University, where he was an instructor in neurology through 1941.

After four years of active service as commander in the navy medical corps, Dr. Kolb was in private practice in neurology and psychiatry for three years before going to Minnesota. During this period, he was consultant to the United States Naval Hospital at Bethesda, Md., and director of research projects at the National Institute of Mental Health. He is author or co-author of a number of scientific articles.

Dr. Kolb is married and has three children, Pamela, 11; Mary, eight; and Richard, four. His wife is the former Clara Currie.

NEWS AND COMMENT

NEW APPOINTMENTS TO DEPARTMENT POSITIONS

New appointments in the Albany offices of the Department of Mental Hygiene include the naming of Robert E. Patton of Albany as associate statistician, and of Henry F. Dylla, Jr. of Bayonne, N. J., as food service advisor. Mr. Patton took up his duties on December 16, 1953 as assistant to Benjamin Malzberg, Ph.D., director of the bureau of statistics. A graduate of New York State Teachers College, Mr. Patton has a master's degree in statistics from the University of Michigan in addition to one in public health. He taught mathematics at Tufts College, Medford, Mass., and taught statistics at the Albany division of the Russell Sage College before his appointment to the department.

Mr. Dylla was appointed to the department's nutrition services to fill the vacancy occasioned by the death of Captain John A. Fields in July 1953. A graduate of the School of Hotel Administration at Cornell, he came to the department in November 1953 from a position as food specialist at the United States Naval Supply Research and Development Facility at Bayonne.

SUMMER WORKSHOPS SCHEDULED

Among the workshops and seminars of interest to psychiatrists and persons in allied disciplines this coming summer will be the 1954 Annual Workshop in Projective Drawings at the New York State Psychiatric Institute from July 19 to July 22. The workshop will be under the direction of Emanuel F. Hammer, Ph.D. and Selma Landisberg. Numerous techniques will be studied. Further information may be obtained from Dr. Hammer at 210 Riverside Drive, New York 25, N. Y.

The Eleventh Summer Seminar-Workshop in General Semantics will be conducted from August 14 to August 29, 1954 at Bard College, Annandale, N. Y. A basic course will be offered, and enrollment is limited to 40.

Yale University has announced the 12th annual session of the Summer School of Alcohol Studies at the university from July 5 to June 21, 1954 with Seldon D. Bacon, Ph.D., director.

The annual summer session at Bethel, Maine, of the National Training Laboratory in Group Development will be conducted from June 20 to July 10. About 125 applicants will be accepted from among persons involved in group problems "in a training, consultant, or leadership capacity in any field."

NATIONAL INSTITUTES ISSUE NEW BOOKLET

A new edition of the booklet *Training and Research Opportunities Under the National Mental Health Act* has been issued by the National Institutes of Health. It covers traineeships in psychiatry, psychiatric nursing, psychiatric social work, clinical psychology, and a new category, "public health mental health." Research fellowships are now awarded to postgraduate investigators only and are available in many fields of medicine and other science. Single copies of the new edition may be obtained without charge by writing to the National Institute of Mental Health, Bethesda, Md.

NEW ALCOHOLISM CLINIC ANNOUNCED FOR BROOKLYN

Grants totalling more than $27,000 annually for an additional alcoholism clinic and research project in New York City have been announced by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene, as chairman of the State Mental Health Commission. The clinic, to be operated at Kings County Hospital, Brooklyn, will be operated by the department of psychiatry of the State University of New York College of Medicine at New York City, which will also direct the research connected with the new project.

CHILD CARE PUBLICATIONS CHANGES ANNOUNCED

Child Care Publications has announced that the *Journal of Child Psychiatry*, at present issued irregularly, will become a quarterly, beginning with the first issue of Volume 3, April 1954. *The Nervous Child* will be increased in page size in a change of format and will continue to be published as symposia on specific problems, one to each issue.

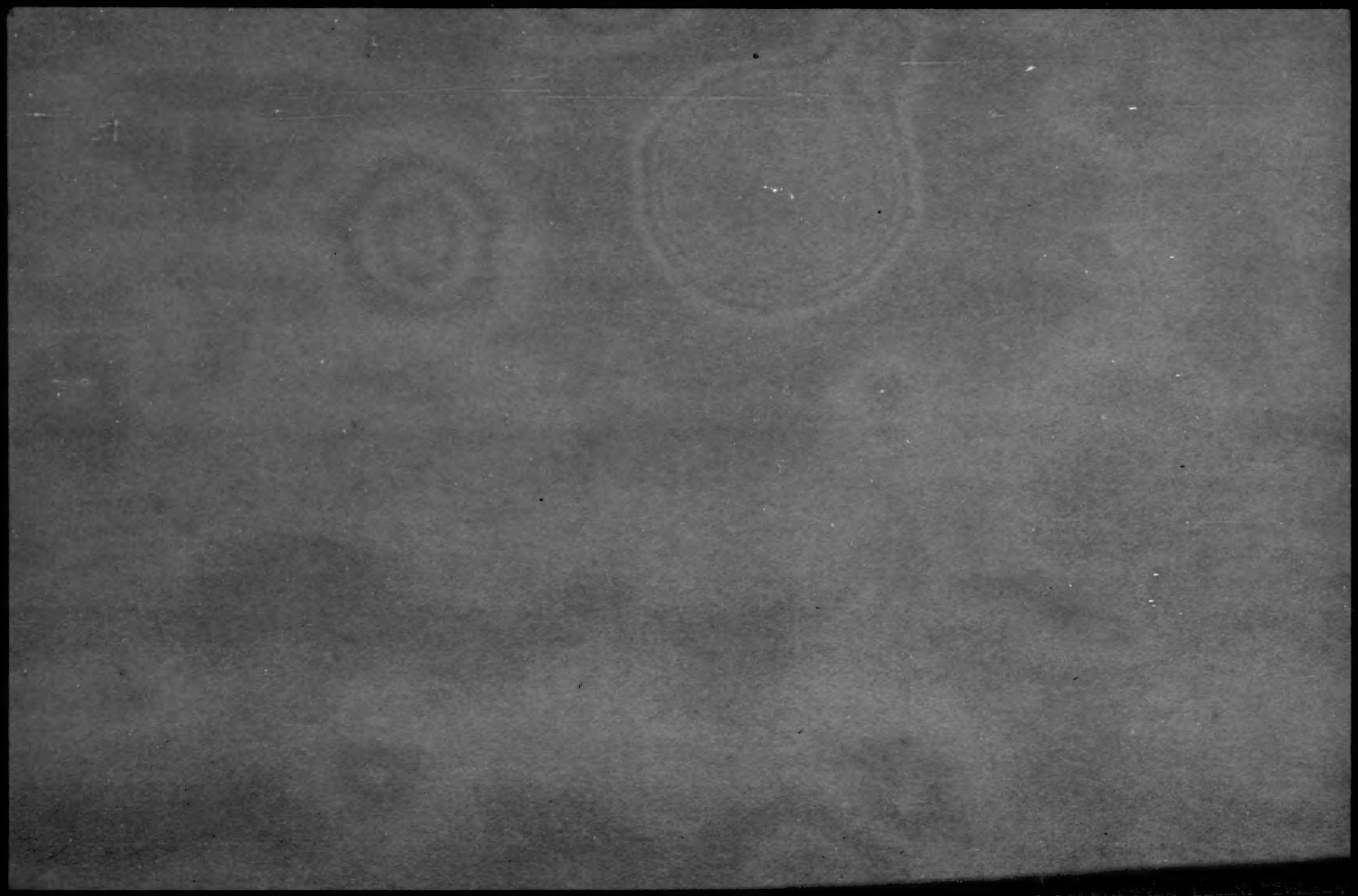
N. Y. HOSPITALS TO HAVE RESIDENT CHAPLAINS

A program to assign 68 full-time chaplains to 24 New York State mental institutions was announced by Governor Thomas E. Dewey on January 16, 1954, after a long study by an interfaith chaplaincy commission in co-operation with Budget Director T. Norman Hurd, Commissioner of Mental Hygiene Newton Bigelow, M. D., and J. Earl Kelly of the Civil Service Department. All 24 institutions will have one or more resident Catholic and one or more resident Protestant chaplains, with Jewish chaplains at 13 institutions. Assignments are apportioned in accordance with the religious faith of the patients in the institutions concerned.

N. Y. REFERENDUM ON STATE HOSPITAL BONDS

A $350,000,000 bond issue for construction of new state mental institutions will be voted on in public referendum next November by the people of New York State as the result of authorization recommended by Governor Thomas E. Dewey and voted unanimously by the 1954 legislature. The present rated capacity of the New York State Department of Mental Hygiene institutions is 86,000 beds, with an actual patient population of 112,000 patients and a present building program which will add only 16,000 beds. This will still leave a shortage of 10,000 beds, which is expected to increase to 25,000 in the next five years—and which construction under the proposed bond issue would be designed to relieve.

The 1954 legislature also authorized a program of state aid to develop and expand community health services, in what is generally regarded as a companion effort to the bond issue proposal to meet the present mental health program. Buildings under the new bond issue would care for new patients; the expanded community aid program is intended to lessen the number of new patients by enlarging and improving community efforts for mental health.



THE PSYCHIATRIC QUARTERLY SUPPLEMENT

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